THE CANADIAN HOSPITAL

OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL

AUGUST, 1947

ARE YOU SUFFERING from "Laundry Pains"?

Struggling with problems of insufficient clean linens... of departments running out of linens between deliveries? These are signs of an overworked laundry, not equipped to meet demands of increased occupancy.

The remedy: modernize the laundry. Up-to-date laundry machines produce more clean linens in less time. Linens are laundered and returned to service on shorter schedule. Departments have ample supplies for any emergency. Quality of work is improved, and the savings in operating costs make modernization pay for itself quickly.

Your laundry, on which every other department depends, deserves your attention NOW. To assist you, our Laundry Advisor will make a survey and submit his recommendations.

Write Today

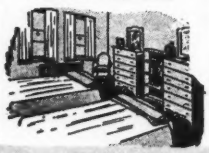
WARDS

• MORE LINENS

OPERATING ROOMS

• MORE LINENS

NURSES' ROOMS



• MORE LINENS

KITCHENS

• MORE LINENS

PRIVATE ROOMS

• MORE LINENS

NURSERIES

• MORE LINENS

DINING ROOMS

• MORE LINENS

EMERGENCY ROOMS

• MORE LINENS

• 2505-bed Sonoma State Home, Eldridge, Cal., replaced overburdened washroom equipment with these CASCADE Automatic Unloading Washers with Companion Controls, and NOTRUX Extractors. Benefits included faster return of linens to service, better quality work, savings in labor and floor space.

REMEMBER...

Every Department of the Hospital Depends on the Laundry

THE CANADIAN LAUNDRY MACHINERY CO., LIMITED

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SCHOOL OF NURSING
AUG 19 1947
UNIVERSITY OF TORONTO

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Pioneer name in parenteral therapy

● A Protein Hydrolysate Solution that is conspicuously reaction-free is another achievement of Baxter research. The perfecting of Protein Hydrolysate Baxter marks an important addition to Baxter's integrated parenteral therapy program . . . with its complete range of solutions . . . sets for separate or simultaneous infusions . . . its wide selection of simplified equipment for standardized procedures. No other method is used by so many hospitals.

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EXPERIENCE..

. . . . gained over a quarter of a century in the designing and production of uniforms, wardwear, binders, O.R. gowns, etc., for hospital and professional use, will soon be available to an increasing number of customers.

BUT—present limits placed on production by inadequate supplies of material prohibit, *with the exception of a few items,* the servicing of new accounts for the balance of this year.

LAC-MAC NURSES' CAPES are one of the exceptions, and can be supplied to a growing group of discerning buyers before chilly days return again. Capes are tailored to individual measurements, embroidered with hospital and individual initials . . . are warm, long-wearing.

The woollens now in stock are comparable to pre-war qualities, in various weights and prices to meet personal preferences. Samples will be forwarded upon request, together with a folder giving measurement requirements, prices, etc.

Write

FOR ILLUSTRATED CATALOG DESCRIBING MORE THAN SEVENTY HOSPITAL ITEMS MADE BY—

HOSPITAL GARMENTS Lac-Mac LONDON CANADA
LIMITED

OVER TWENTY-FIVE YEARS MANUFACTURING PRODUCTS FROM TEXTILES FOR THE MEDICAL PROFESSIONS, THEIR INSTITUTIONS AND SERVICES.

Contents

Vol. 24 **AUGUST, 1947** No. 8

SPECIALLY DEVELOPED FOR HOSPITAL USE

Durable • Practical • Attractive

SIMMONS HOSPITAL ROOM No. 3

includes all the features which assure long and efficient operation. Sturdy steel construction gives it durability and fire resistance. Its practical design meets the specialized requirements of hospital service. To assure silence, drawers of dresser and somnoe operate noiselessly. Beautiful harmony of color provides a restful environment.

Sets are available in many other attractive colors and wood grain finishes.

SIMMONS

LIMITED

Canada's leading manufacturers of Specialty Sleeping Equipment and Hospital Furniture.

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The Federation of Hospital Associations in Canada in co-operation with the Federal and Provincial Governments and the Canadian Medical Association

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CANADA'S LARGEST MILITARY HOSPITAL

relies on Johns-Manville for Sound Control

SUNNYBROOK HOSPITAL, Toronto, is a typical example of a 100% Johns-Manville Sound Control job. This up-to-date military institution relies on J-M Perforated Transite Panels to keep all corridors comfortably quiet. Sound-absorbing J-M Fibretone assures restful silence in wards, dining rooms, canteens and recreation rooms.

In addition to noise elimination there are many other advantages to J-M Acoustical Materials. For example some are fireproof for added safety . . . others have removable sections to provide easy access to the enclosed ceiling space and there are specially treated types that are easy to clean — may even be washed or painted repeatedly without impairing their high sound-absorbing efficiency.

YOUR NOISE PROBLEM, TOO, should have the benefit of Johns-Manville experience!

Whatever your problem in sound control — Johns-Manville can provide a solution that is scientifically correct. Our experience in controlling sound dates back 35 years — today, when you choose J-M Acoustical Materials *for any type of job* you get full benefit from this backlog of knowledge.

Johns-Manville not only recommends the *right* acoustical material for each specific condition — J-M follows through with the *correct* installation. Trained J-M construction crews see that these sound-absorbing materials are installed to assure maximum performance in the proper manner. That's the all-inclusive service . . . the undivided responsibility you receive from Johns-Manville!

For complete information on Johns-Manville Acoustical Materials send for our brochure, "Sound Control". This interesting booklet is yours for the asking, just write Canadian Johns-Manville, Toronto, Montreal, Winnipeg or Vancouver.

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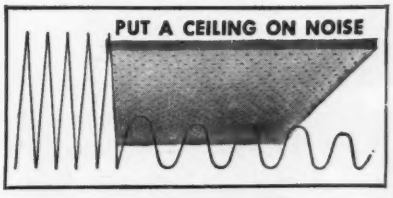

A525

JM Johns-Manville *Pioneers in* Sound Control Member of

"Sanitas" ALUMINUM LAUNDRY CHUTES

● **"Sanitas" Laundry Chutes provide rapid, sanitary transmission of soiled linen from all floors to basement. Entire construction is aluminum, except for hardware. Glass Panel in doors optional. Require no painting. Can be flushed down with water from flushing ring at top. "Sanitas" Chutes can be installed in already completed buildings, Hospitals, Hotels, Institutions. Write for "Laundry Chute folder."**

Let us look at your drawings, suggest a layout and quote a price.

Solid Aluminum Panel Door

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catch it on the wing!

Whip the bar across and you've caught that fleeting evidence of pathology *surely, clearly, quickly* . . . because it's a **Picker S-4 Automatic Serialographic Table** you're operating. The Picker S-4 offers the most advanced and inclusive facilities for automatic spot-film radiography, in both gastro-intestinal and myelographic fields.

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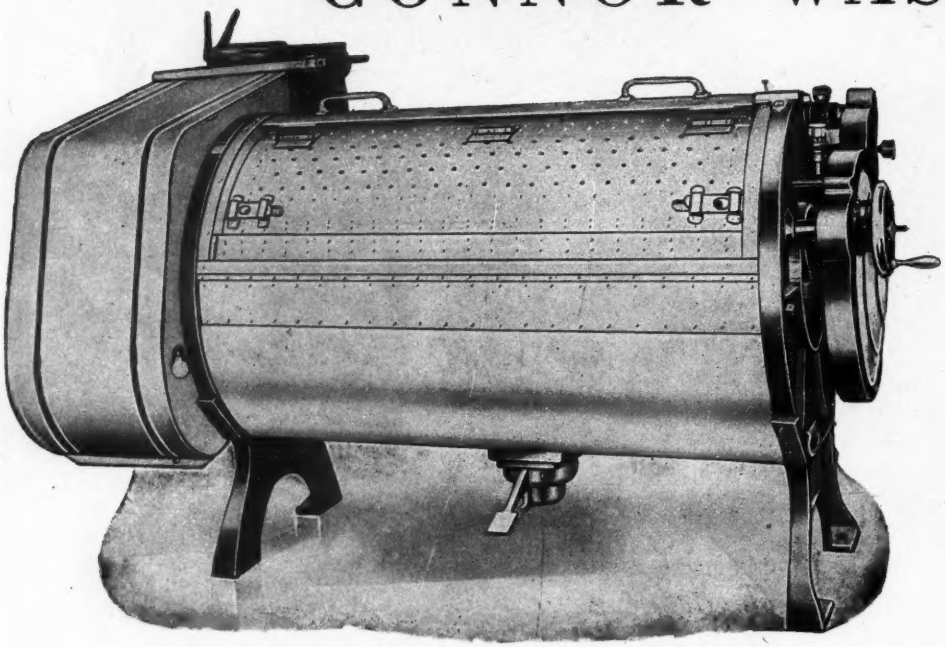
Low Initial Cost — Low Operating Cost

Feature These High Quality All Metal

CONNOR WASHERS



You Can Save Money With This Time Proven Laundry Equipment

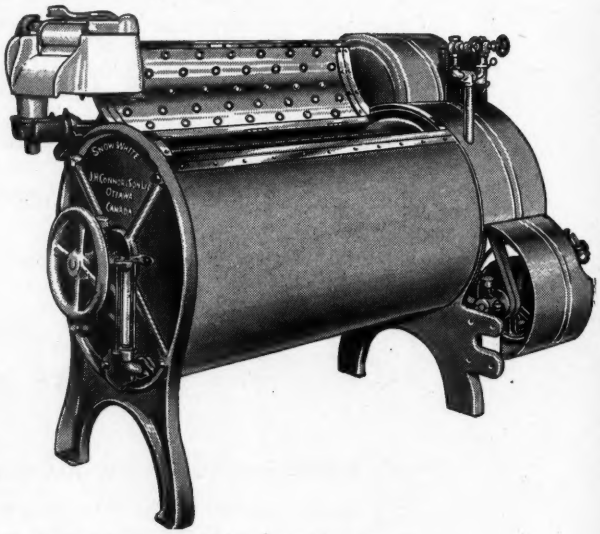
THE OTTAWA WASHER

No. 4 Ottawa Washer, complete with ¾ h.p. electric motor, single or three phase, 110-220 volt. Cylinder of hard brass, nickel plated and polished, 28″ x 48″. Capacity 40 sheets or 60 pounds dry clothes. Cylinder revolves on large, double race ball bearings, reducing power consumption 50 per cent. Weight 1,500 pounds.

No. 3 Ottawa Washer identical, but with 28″ x 42″ cylinder. Capacity 30 sheets or 50 pounds dry clothes.

THE SNOW WHITE NO. 2 WASHER

Complete with ½ h.p. electric motor and wringer. Cylinder 24″ x 40″. Capacity 22 sheets or 36 pounds dry clothes. Floor space 38″ x 64″. Weight 825 pounds. The greatest value ever offered for a metal washer of this size. Satisfied users from coast to coast.



Metal Washers from 36 to 150 pounds dry clothes capacity. Tumbler Dryers, Extractors, Ironers, Laundry Trucks. Write for catalogue and price list. Convenient terms arranged.

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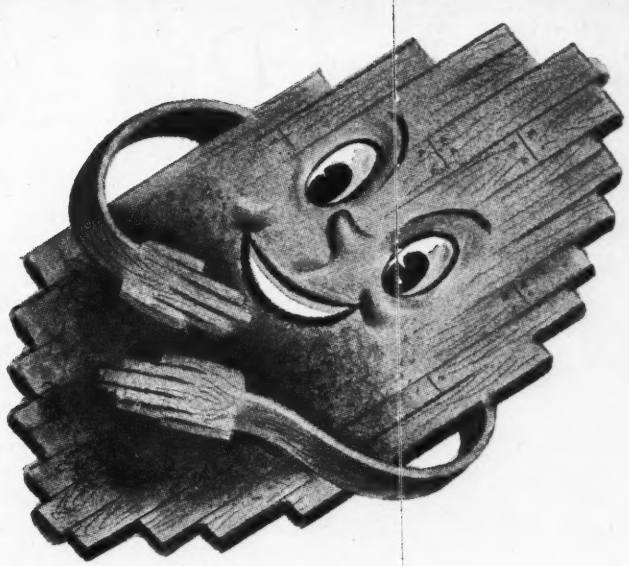
WINNIPEG—242 Princess St. ***Quality Washers Since 1875*** **MONTREAL—4026 St. Catherine W.**

Give your floor the

WESTONE TREATMENT



HUGGING ACTION

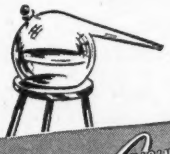
keeps dust grounded!

Believe it or not, foot traffic can't kick up annoying dust with Westone — the different kind of liquid chemical developed for floors by West. Westone's "hugging action" holds dust close against the floor surface; prevents it from "taking off" into the atmosphere until ready to be swept away.

Moreover, for all types of old and new wood floors, Westone doesn't merely give *ordinary* protection against wear. It actually *strengthens* their surface, and effectively *removes* many harmful foreign elements. Waxed floors, concrete floors, composition floors and other types also benefit from the "Westone Treatment."

Non-staining, Westone actually improves the appearance of your floor with every application. Not a floor oil, it spreads so easily that one person can do the work of three.

One of West's nation-wide staff of over 475 trained representatives will be glad to help you with your floor maintenance problems.



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Products That Promote Sanitation

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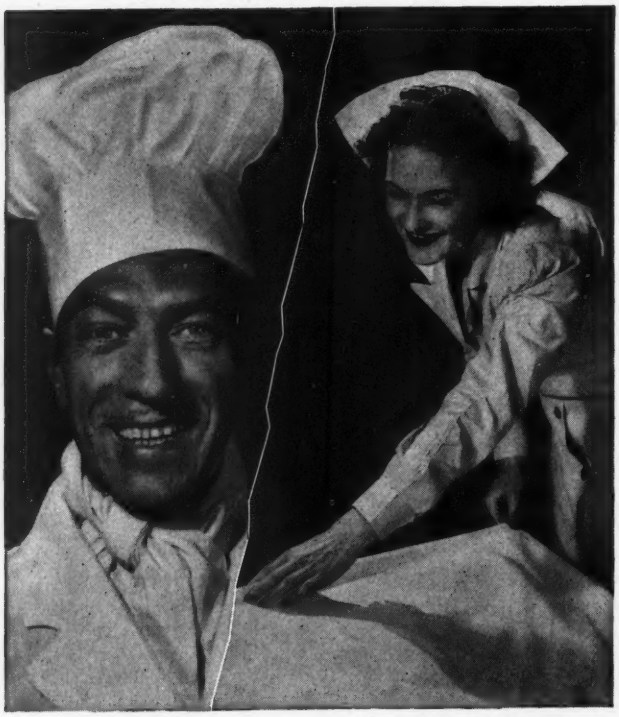


Cut laundering costs with DRAX

TRADE MARK REG. CANADA PAT. OFF.

. . . the renewable fabric finish that resists dirt . . . soil . . . and moisture!

Uniforms stay crisper, cleaner-looking longer . . . wash more easily . . . when they are protected with Johnson's DRAX! And both these advantages mean a cutting down of laundering costs!

DRAX . . . made by the makers of Johnson's Wax . . . is an amazing new, *invisible* fabric finish that gives each thread of the fabric the wonderful protection of wax. Dirt slides off, water and liquids wipe easily away . . . because dirt is not ground into the fabric it washes easier, cleaner without fabric-fatiguing rubbing and scrubbing.

DRAX is grand for curtains, tablecloths, place mats and other washable things, too. It saves so much time in the washing . . . so much wear . . . and keeps things looking cleaner longer, it's well worth looking into. Find out about DRAX today!

DRAX TRADEMARK REG. CANADA PAT. OFF. **is made by the makers of JOHNSON'S WAX**

(a name everyone knows)

S. C. JOHNSON & SON, LTD.
Brantford, Canada

Across the Desk

By C. A. E.

DURING a visit recently to one of the cities south of the border we attended an evening Church service which was conducted by Richard Maxwell, the well-known gospel singer and radio entertainer, and his group of singers.

Mr. Maxwell, the Larkin sisters quartet and Miss Helen Benner, accompanist and mezzo-contralto, sang a number of selections including hymns and classical and popular songs.

The principal function of the group is to entertain and conduct brief services in the Veterans hospitals throughout the country, under the auspices of the Protestant Churches of the United States. At each hospital they visit twenty radio receiving sets are presented to patients.

As an indication of the inspiration and spiritual guidance they are able to give the disabled veterans, Mr. Maxwell related that following one of their programs the administrator of the hospital said there had been less call for morphine and other sedatives that night than for many months past.

* * * *

Contest for Publications on Public Relations

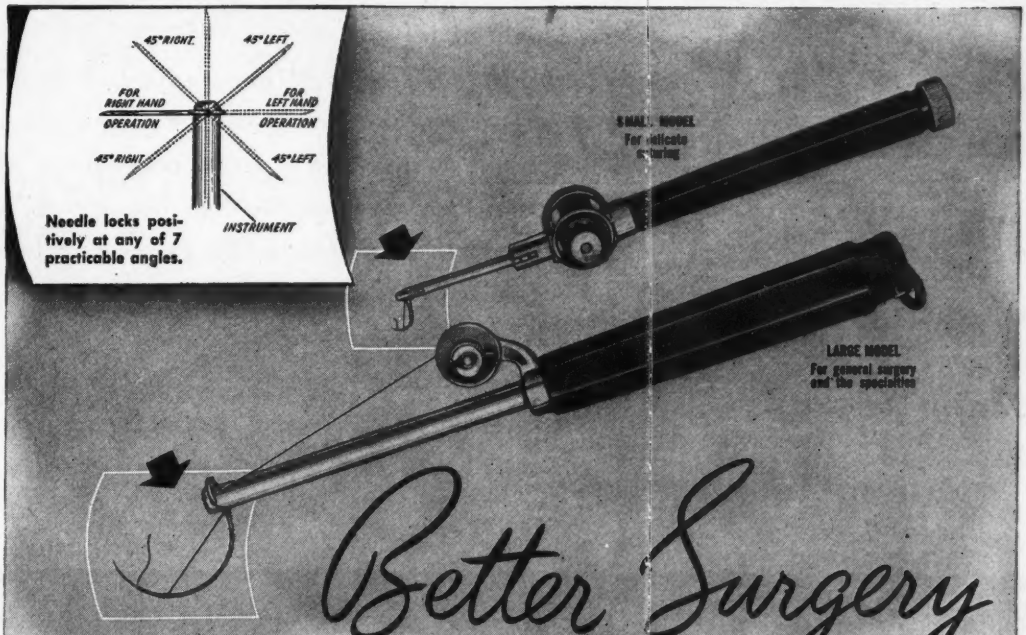
Contests for employee information booklets and school of nursing brochures published by hospitals are being conducted by the Public Relations Council of the American Hospital Association. Awards will be made at the Association's Annual Convention in St. Louis, September 22-25.

Objective of the contest is to stimulate interest in these two kinds of publication as public relations tools and to encourage production of better publications. Employee information and nursing school booklets were chosen as publications for contests because employee relations and nurse recruitment are subjects of more than ordinary interest at this time. These contests replace the Public Education Contest of former years.

Publications submitted will be judged for content, readability, general attractiveness, use of pictures and illustrations, style, format, tone and over-all effectiveness. All school of nursing brochures, booklets and catalogues will be judged as one group; but the employee information booklets will be broken into two sections, those from hospitals with 100 or fewer beds and those from hospitals with 101 or more beds.

Entries, which must be accompanied by an entry form, are to be mailed to the Council on Public Relations, American Hospital Association, 18 East Division Street, Chicago 10, Illinois, on or before September 1, 1947. Entry blanks may be obtained by writing to the Council. The contests are open only to member institutions of the American Hospital Association.

(Continued on page 16)



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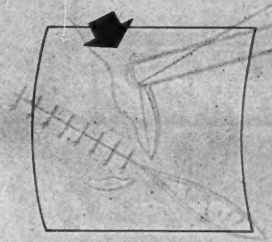
WITH FREEDOM FROM NEEDLE HOLDER DIFFICULTIES

In the Singer Surgical Stitching Instruments the conventionally separate entities of needle, needle holder and suture supply have been united in one single instrument. • This ingenious construction entirely eliminates holder difficulties. Singer needles are securely locked at any of seven practicable angles . . . thus slipping of the needle from the holder because of too loose clamping, or breaking off because of too tight clamping, or shifting of position are quite impossible. Yet the needle may be quickly loosened for adjustment and relocking in a new position by a simple turn of the handle lock nut. • Send for a comprehensively illustrated booklet to obtain full details about the many other advantages of the Singer suturing instruments . . . increasingly the choice of discriminating surgeons.

SINGER

SURGICAL STITCHING INSTRUMENTS

Bobbin-wound sutures (catgut, cotton, nylon, silk) available through Davis & Geck, Inc., Brooklyn, New York.



* *Our three newest films available for showing are (1) "Rehabilitation of Parkinson's Syndrome", (2) "Treatment of Major Neuralgias", and (3) "Removal of Tumor of the Bladder".*

Singer Sewing Machine Company
Surgical Stitching Instrument Division, Canada
Dept. C.H. 87

Without obligation, please send copy of illustrated booklet.

Name .....

Address .....

City ..... *Prov*.....

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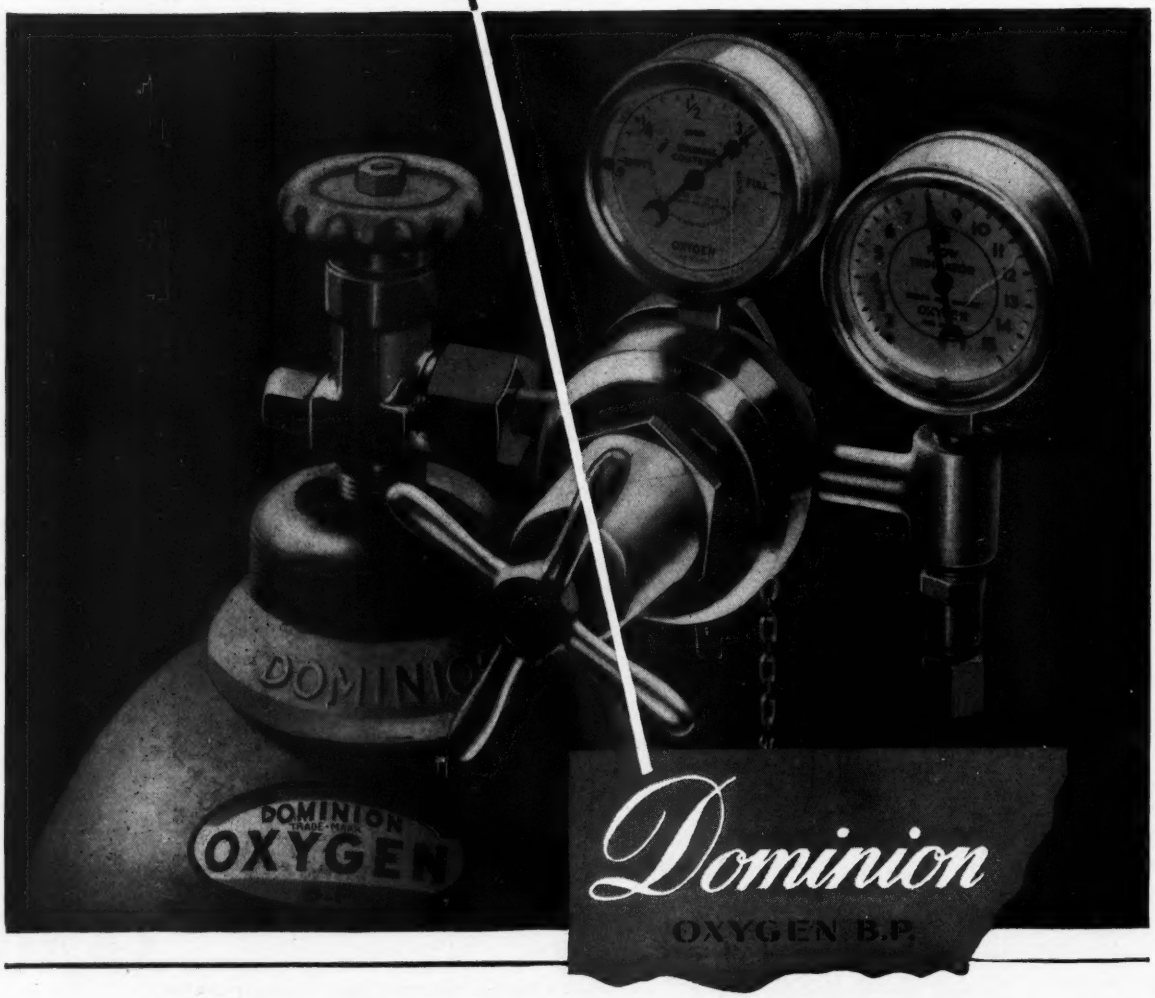
Of Course, There Is an All-Purpose Oxygen Therapy Regulator

It's the LINDE R-50 Regulator for all types of oxygen administration. The R-50 is the logical choice for your standard equipment because: **1.** *It can be used on every type of oxygen administration equipment.* **2.** *Humidifiers can be attached when necessary.* **3.** *Long-lasting dependability is insured.* **4.** *The gauges are easily read and understood.* **5.** *Busy technicians save time because one regulator fits all requirements.* **6.** *Storage space is saved because fewer regulators are needed.* **7.** *The LINDE R-50 is always ready in an emergency, no matter what type therapy is indicated. Write for a descriptive folder—ask for Bulletin M.*



DOMINION OXYGEN COMPANY, LIMITED DOC **159 Bay Street, Toronto 1, Ontario**
MONTREAL WINNIPEG VANCOUVER

"Dominion" and "Linde" are trade-marks.

What every Doctor should know about the

CONTINENTALAIR

ICELESS OXYGEN AND AIR CONDITIONING UNIT

There comes a time in every doctor's practice when a patient requires treatment which includes the administration of oxygen, other gases or the recuperating comfort of bedside air conditioning. When that occasion arises the physician in charge should know these important advantages of the Continentalair.

● **DUAL PURPOSE** The CONTINENTALAIR provides a quick and modern means of correctly administering oxygen therapy or providing bedside air conditioning. Within a few minutes, temperature is reduced to prescribed requirements.

● **ICELESS** No wasted time waiting for melting ice to reduce temperature. No disturbing of patient to replenish ice supply. No wide fluctuation of temperature.

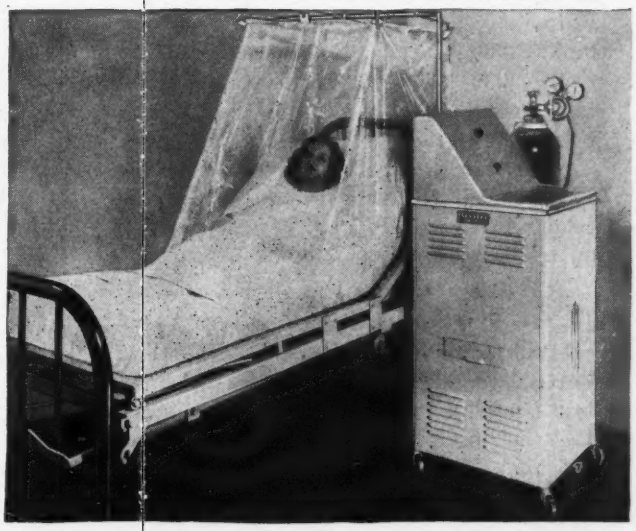
● **AUTOMATIC CONTROL** Simply plug into the electrical circuit, set the temperature indicator, and press the button. The prescribed temperature is then maintained automatically. Oxygen, when prescribed is regulated in the accepted practice.

● **CLEANS THE AIR** Air is water screened, to remove air-borne irritants. This may be especially valuable to allergy patients. Excess humidity is removed from the canopy to provide for restful comfort.

● **CORRECT CIRCULATION** Canopy air is completely changed every 15 seconds, thereby assuring the patient of a continuous supply of fresh, clean oxygen and air.

● **ECONOMICAL** Low electrical current requirements make CONTINENTALAIR an exceptionally economical unit to employ. Electric current consumption averages a few cents per day.

● **RELIABLE** CONTINENTALAIR is the only automatic iceless oxygen tent with a proven record of dependability. For more than 10 years, leading hospitals have relied on CONTINENTALAIR performance. Continentalair is 10 years ahead.



VISIONAIRE CANOPIES NOW AVAILABLE

Shown here with the CONTINENTALAIR is a VISIONAIRE **Disposable** Canopy. VISIONAIRE Canopies are **all clear;** the patient enjoys full visibility, thus minimizing the development of claustrophobia. VISIONAIRE Canopies are so low priced that each patient may be issued a brand new canopy to avoid any possibility of cross infection. Available in standard thickness or double thickness for extra durability. Immediate shipments for all makes and types of oxygen tents.

Exclusive Canadian Distributors:

THE Stevens COMPANIES

TORONTO WINNIPEG CALGARY VANCOUVER

WAR ASSETS
CW Bulletin

THE FOLLOWING WAR SURPLUS ITEMS ARE AVAILABLE

WATER STERILIZERS

20 New Water Sterilizers, Jenkins Type. Hotpoint immersion heater. 10 gallon tank. 3000 Watts, 12 Amps., 25 and 60 Cycles, 230 Volts, A.C. and D.C. Copper tank, nickel plated. Overall height including cover: 26". Tank Dia.: 15". 1" x ¼" flat iron constructed stand 31" high x 15½" dia. Chromed drain tap. White porcelain thermometer and 3 heat electric switch, porcelain base and bakelite cover.

14 New Single Tank High Pressure Water Sterilizers, 15 gallons capacity, gasoline heated. Inside tank is seamless tin lined brass, outside tank stainless steel. Dim. of tank 30" high, 18½" dia. Dim. of stand 39" high, 20" wide. Complete with valves, thermometers, drain and 4 burner gasoline heater.

Address all enquiries to:

**Branch Sales Manager,
War Assets Corporation,
9600 St. Lawrence Blvd.,
Montreal, Que.**

Watch For Further Announcements

372

WAR ASSETS CORPORATION

Across the Desk

President of Surgical Trade Association

Benjamin F. Hirsch, Executive Vice-President of Davis & Geck, Inc., was elected President of the Manufacturers' Surgical Trade Association. The annual convention at which the election took place was held at The Homestead, Hot Springs, Virginia. He is also President of the Surgical Suture Manufacturers' Association and has been an officer of Davis & Deck since it was founded in 1909.

* * * *

Quick Change Handle Featured on New Cory Decanter

The Cory Model CDA Serving Decanter, newest addition to the Cory line of commercial coffee brewing equipment, has a quick change handle designed to eliminate one of the common complaints of institutions who now use glass coffee serving decanters.

When an ordinary glass serving decanted is used and becomes cracked or broken, it is necessary to locate a screw driver, then go through an elaborate and time-consuming process to remove the handle and replace the broken bowl.

When the new Cory Model CDA Decanter is used, all that is necessary to remove and replace the handle is a quick turn of a handy thumb crew. The handle and chrome collar then snap off as shown in the illustration and can be immediately snapped onto the replacement decanter.

* * * *

New Catalogue on Pipe Coils

Crane Limited have just compiled and printed a 48-page book which they feel will be extremely helpful to all users of pipe coils for industrial or commercial purposes. It is divided into three sections: one on well-

(Concluded on page 20)

They look to you, Doctor..

"It has to be considered whether the damage to tissues, whether gross or only microscopic, will outweigh the advantage possibly gained by killing bacteria; some antiseptics are caustic or irritan . others comparatively bland." *Garrod, L.P., and Keynes, Geoffrey, L. (1937) Brit. Med. J.,2.1233*

YOU, in choosing an antiseptic for the prevention, or chemotherapeutic for the treatment, of an infection, have knowledge and experience to guide you. But what of the unskilled person using an antiseptic at home! What does he know of this important consideration! Nothing, or next to nothing at all.

YET HERE is the crucial problem of all antisepsis; most acute, obviously, with antiseptics which are toxic at all bactericidal strengths; progressively less acute as the margin widens between the bactericidal dilution and the dilution at which toxic effects first appear.

CONSIDER NOW an antiseptic with which the problem hardly arises at all. One which, though bactericidal in considerable dilution, is bland at any strength. One which may be applied direct to the tissues without risk of either injury or interference with natural healing processes. Such a non-poisonous antiseptic is 'Dettol.'

MOREOVER, and most importantly, 'Dettol' has low selectivity. It is rapidly lethal to a diversity of pathogenic organisms, including *Strep.pyogenes*, *Staph.aureus*, *B.coli*, *B.typhosum*, and such wound contaminants as *B.proteus* and *Ps.pyocyanea*. And it remains active under clinical conditions, i.e., in the presence of blood, pus and tissue debris.

ADD TO THESE remarkable properties that 'Dettol' is pleasant to smell and agreeable to use, and that it does not stain either linen or the skin, and it will be seen that here is an almost ideal antiseptic for general use in Canadian homes, as it already is in millions of homes in other parts of the Empire.

'DETTOL' OBSTETRIC CREAM
is a preparation of 30 per cent. 'Dettol' in a suitable vehicle, the right concentration for immediate use in obstetrics. Applied to the patient's skin and to the gloves of the operator, it forms for more than two hours a dependable barrier against re-infection by haemolytic streptococci.

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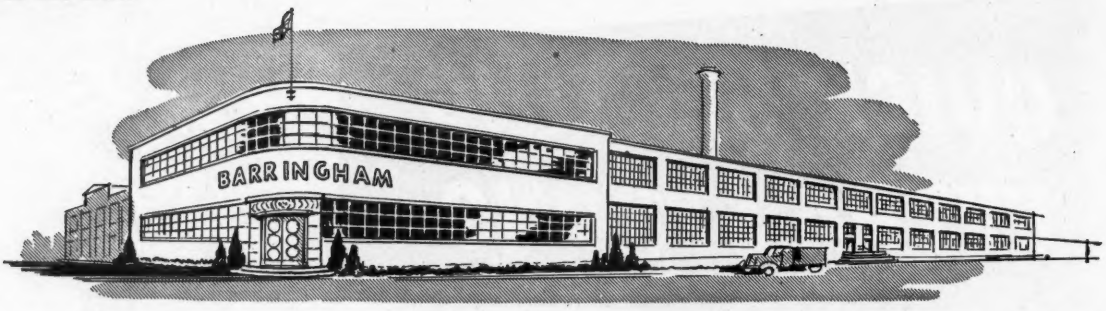

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* * * *

(Concluded from page 16)

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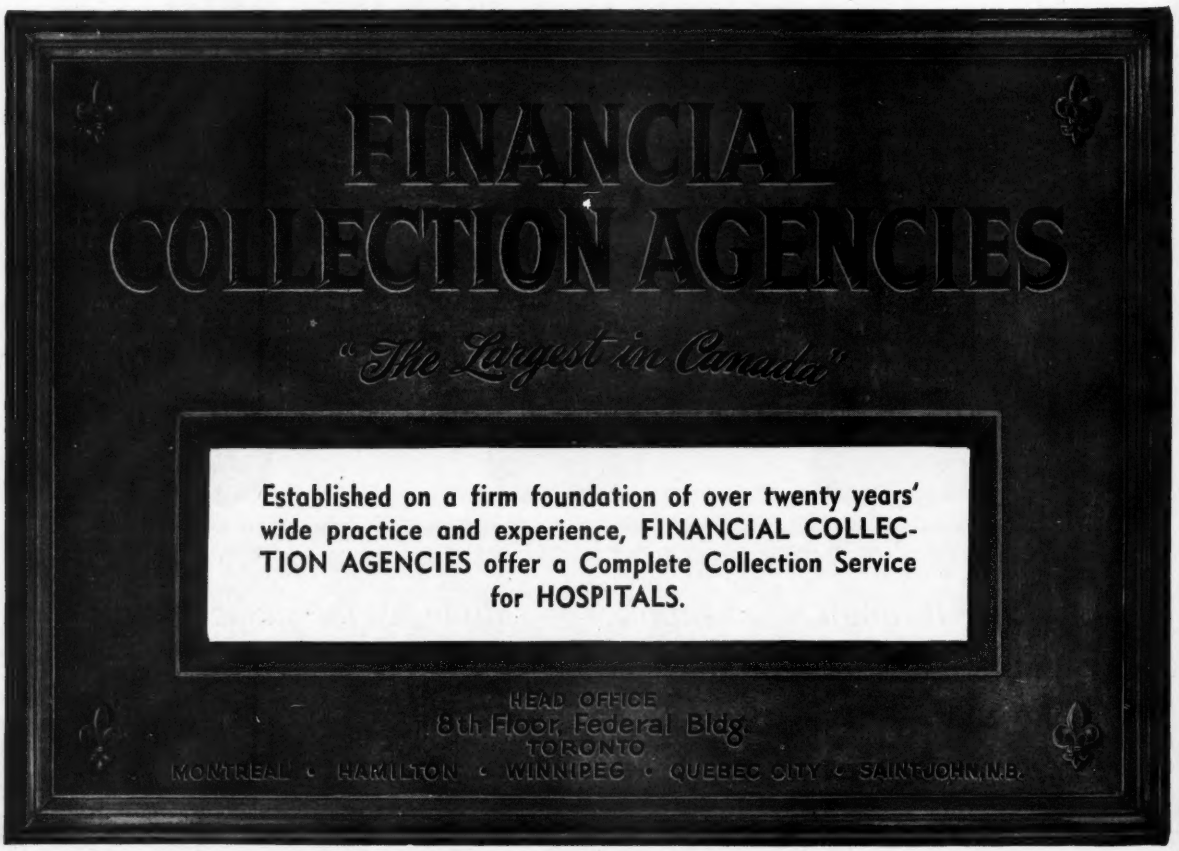

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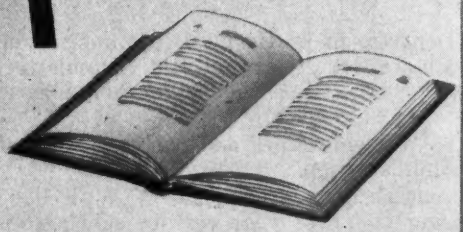

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*American Martyrs To Science Through The Roentgen Rays by Percy Brown, M.D. Published by Charles C. Thomas, Springfield, Illinois.

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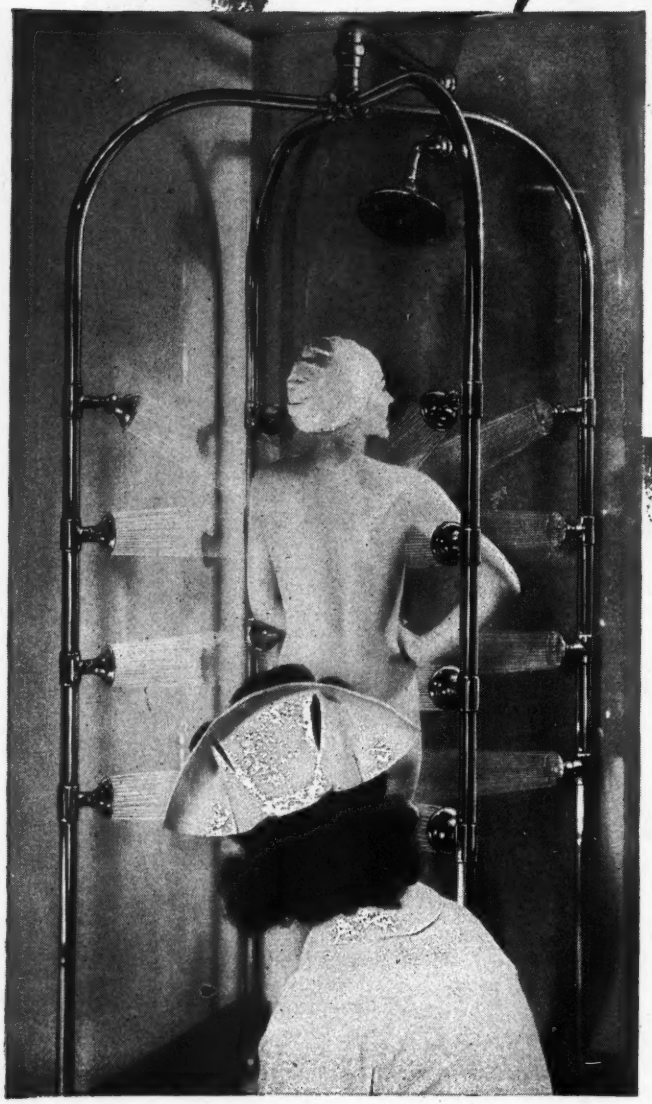

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Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, August, 1947 Vol. 24 No. 8

A Solution MUST be Found

Harvey Agnew, M.D.

TO what extent is the gravity of the situation with respect to the provision of nursing care and other service realized by hospital leaders, governments and the public at large?

That it is a serious problem today is only too well recognized by every administrator, every director of nursing, every doctor, the nurses trying to keep services going, and by almost every patient. But most of us are still "carrying on" day by day, hoping that the situation will ultimately correct itself. We talk vaguely about the law of "supply and demand". A few years ago we said: "It's the war; wait till the war's over". Now, with the war long since over, conditions are as bad as ever; so we state with conviction that the next depression will shake everything back into a more workable society. But the next depression will probably leave us with such a jumble of half-baked labour, relief and other laws that confusion will be compounded, and there may well be less opportunity or incentive for sound leadership.

What we must realize is that we have with us now a situation which, if not solved, will become a MAJOR NATIONAL CALAMITY. ..

The simple fact is that we are not heading towards any really permanent solution of nursing service, either within or without the hospital. We are patching up the old system, getting by day by day, and hoping that someone else will hit upon a solution. Early in the war our national and military leaders warned us that conditions would become worse, much worse, before they would become better. In the long subsequent years we found their prophecy only too true.

It can be said with equal assurance that our nursing services in this country are going to become worse in the next few years and that improvement will only be in relation to the steps taken to meet the situation. The demand for qualified nurses is steadily increasing and will grow tremendously in the next few years. Hospitals, woefully understaffed today, must increase their facilities by many thousands of beds. Never before has there been such a need for expansion and never before have so many hospitals had plans ready for building when conditions and funds permit. But we must realize that if some magic wand were to bring into creation the added facilities needed, only a small proportion could be opened because of the impossibility of getting adequate personnel.

We have barely started upon our public health program. Hundreds of nurses will be needed by our municipalities and governments and, if a full-blown program of health insurance should eventuate, the numbers needed might well be numbered in thousands. Health insurance measures, too, will probably include visiting nurse service, absorbing another large portion of each year's output. Industrial hygiene is being developed at a rapid rate and a basic feature of this program is the industrial nurse. The number of nurses left to care for the sick in hospital is bound to dwindle, and for that matter, none of the fields will be able to obtain sufficient numbers.

It might well be asked, what are the present and potential users of nurses doing to help the hospitals finance the training cost of the nurses they use?

A regrettable feature of this situation is that none of these employers of graduate nurses — industry, public health, D.V.A., T.C.A., et cetera — train nurses themselves. It is all left to a few civilian hospitals. Moreover, the hospitals, having to maintain 24-hour, seven-day service, find it hard to compete against the abbreviated schedules offered by public health and industry. Were it not for this deflection of hospital graduates into fields none-existent a few decades ago, there would be no shortage of nurses in hospitals today. Many people are of the opinion that nurses on graduation should be re-

quired to serve six to twelve months at prevailing salaries in some hospital before going elsewhere.

The time has come when we must face the situation squarely. Unless a far-reaching program designed to correct these difficulties is put into operation without delay, *our entire program of augmented health care will need to be abandoned.* Without trained people to provide nursing and other care, it will be quite impossible to carry out any national or provincial health program. Should an epidemic on a national scale occur, the result would, indeed, be calamitous. More active steps to forestall this situation must be taken NOW.

This makes the situation of direct and immediate concern to our public health authorities, municipal, provincial and federal; to the medical profession; to industry; to compensation boards and to all other health agencies and boards, to the life insurance field; and to the general public whose own health and welfare are at stake. The main responsibility for finding a solution rests not so much with the nurses and the hospitals as with the governments and other consumers of nurse services. It is obvious that the situation is so serious that nothing short of a thorough study of the subject from every angle will suffice. Moreover, the solution, or solutions, must be based on the long range view; every effort must be made to anticipate the picture twenty-five years hence and to evolve an approach with that in mind.

The Joint Committee, representing the Canadian Nurses Association, the Canadian Hospital Council, the Canadian Medical Association, the Department of Health and Welfare, and the Department of Veterans' Affairs, has begun to realize the enormousness of its undertaking. What began as a simple study of present needs and their remedy has become one which must be treated as of first magnitude if it is to get to the bottom of the difficulty and find adequate solutions. It is going to require a good deal of outside assistance.

Comprehensive Study Needed

It is apparent that the study must encompass several major undertakings:

1. *There must be a comprehensive factual survey of present conditions.* How serious is the shortage of nurses and subsidiary workers? What are present salary and working conditions in hospitals? How do they compare with those of other groups? What is the state of student enrolment? What percentage of graduates stay in institutional work? (This phase of the study will require competent direction and much field assistance.)

2. *Is our system of providing nursing service in hospitals the most efficient and economical one?* Are we wasting the time of trained personnel? To what extent can employment of the subsidiary worker solve this difficulty? What controls are necessary? Has the time come when the traditional field of the graduate nurse should be re-analyzed and new allocations of duties set up as between the nurse, the physician, the intern, the ward assistant or practical nurse, the technician, the ward secretary, the nurse clinical assistant, the dietary and other staffs?

3. *Are we wasting nurse power in other fields?* Could some of the present duties of the public health nurses be assumed by others? Is the industrial nurse devoting all of her time to strictly nursing care duties? What about T.C.A. stewardesses? How many are receptionists in doctors' offices, or are demonstrating food, clothing and appliances, et cetera?

4. *What is the cost of operating a school for nurses?* Does the hospital gain or lose by operating a school?

5. *Should our system of nurse education be revised?* Is the time-honoured system still the best, or should it be revamped to conform to present-day educational principles and methods adopted in the other fields of education? Should the course be freed of non-nursing tasks? Could it be reduced in length without deleterious effect? To what extent could instruction be improved by centralization? Should school and hospital finances be separated (as in the proposed four-year experiment)? What effect would these changes have upon the financing of hospital operation? Is it advisable to operate a school for nurses and a school for nurse assistants, or practical nurses, in the same institution? Is there merit in the suggestion of a two-year course in nursing for general duty and a longer course for administrative or special work?

6. *What are the trends for the future?* To what extent will the growth of health insurance increase the demand for nurses? What will be the position of hospitals in the health scheme of the future? How will they be financed? What must be our annual output of nurses and trained subsidiary workers twenty-five years hence? Will it be necessary for hospitals to revise, perhaps downward, their conception of standards in nursing care? If hospitals must conform to the spreading pattern of labour today to do less and less for more and more, how will the greatly-increased cost of hospital care be passed on to the public?

Study Must Be Authoritative

Unless the study to be made answers these and many other questions it will fall short of its objective and a lasting solution will not be found. Moreover, the study must be sufficiently authoritative that it will command the attention and acceptance, no matter how much it hurts, of the hospitals, the nursing and medical professions, the governments and the general public.

If the hospitals have been remiss the sooner they realize their shortcomings the better; if a radically new approach to nurse education is needed, present studies in that direction should be intensified; if nursing service duties should be re-allocated, the professions concerned should establish new boundaries; if added public assistance through government channels is essential for nurse education or hospital operation, recommendations to that effect from such a study would bear much weight with governments.

A study of this scope will require some financing, for there would be needed a carefully-chosen director of study, a statistician, a staff, probably consultants in those fields in which the director is not an authority. Much of the work could be done on a provincial basis, but the initial planning, the co-ordinating and the summing up would need to be done by a national group. This is a project which needs further attention without delay by our national hospital, nurse and medical organizations, their provincial counterparts, the federal government and the various provincial governments.

Health Studies of Eskimoes Delayed by "Nascopie" Loss

WHEN the sturdy little Hudson's Bay Company's Arctic supply ship, *Nascopie*, foundered on the rocks off Cape Dorset in the Hudson Strait last month on what was to have been her final annual voyage toward and beyond the sixtieth parallel, plans were delayed for further studies of the health of the Eskimoes in that vast northern region.

Dr. Sinclair, professor of biochemistry at Queen's, planned to make scientific observations in the remote settlements visited in the first half of the Eastern Arctic Patrol and was to have been joined at Southampton Island early in August by the other members of the party who were to be flown to their destination. These were: Dr. Malcolm Brown, associate professor of medicine, Dr. L. B. Cronk and Dr. G. C. Clark. The doctors in the group planned to provide general medical services for the Eskimoes during their stay of approximately six weeks.

Other doctors on the *Nascopie's* passenger list included: Drs. H. W. Lewis, Ottawa, and James Cumming, Toronto and Saskatoon. Also aboard was Edward Bind, Toronto optometrist, who was to have disembarked at Southampton Island, the *Nascopie's* next port of call, to engage in biological studies.

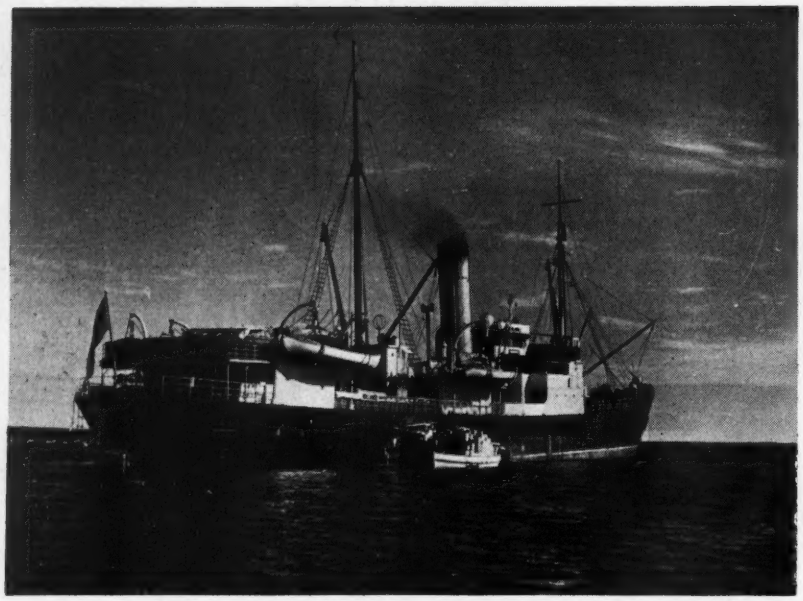
Above: Dr. Walter Crewson of Hamilton examines eyes of Eskimo woman in a corner of one of "Nascopie's" holds.

Left: Dr. James Osborne examines Napatchie of Fort Ross in the "Nascopie's" dispensary.

The purpose of the study was to collect information on the incidence of diseases among the Eskimoes, both in their native surroundings and in areas near trading posts. This data would have been useful in determining the Eskimoe's special needs which must be met if they are to be supported eventually on white men's supplies. Particular attention was to be given to the general nutritional status of the natives, and to ketonaemia — the accumulation of ketones in the blood of persons *on high fat diets.*

Queen's University was assisted by various government departments in arranging the expedition. The medical research division of the National Research Council and the Indian health services division of the Department of National Health and Welfare were helping to meet the cost of scientific apparatus and other expenses. The Department of National Defence, the Department of Transport and the Bureau of the Yukon and Northwest Territories were co-operating in the provision of transportation by sea and air, and the loan of equipment and buildings.

This scientific investigation was to have continued those of last year's mission when, for the first time, the medical staff was under the direction of the Department of National Health and Welfare, which more than a year ago assumed control of Eskimoes and Indian health administration. Last year's survey by Department officials and co-operating medical men proved to be the most



All Canada mourned when the gallant little ship, veteran of 32 trips on the Arctic Patrol, foundered last month on what was to have been her final voyage. She was the only link with civilization for isolated missionaries, Hudson's Bay Company employees and trappers.

extensive examination of the health of the 6,000 Eskimoes inhabiting Canada's eastern Arctic region that has ever been undertaken. Besides the general physical examinations and the search for tuberculosis, the natives received surgical treatment, eye tests and glasses where needed, dental care, inoculations and instructions on proper maternal and child hygiene.

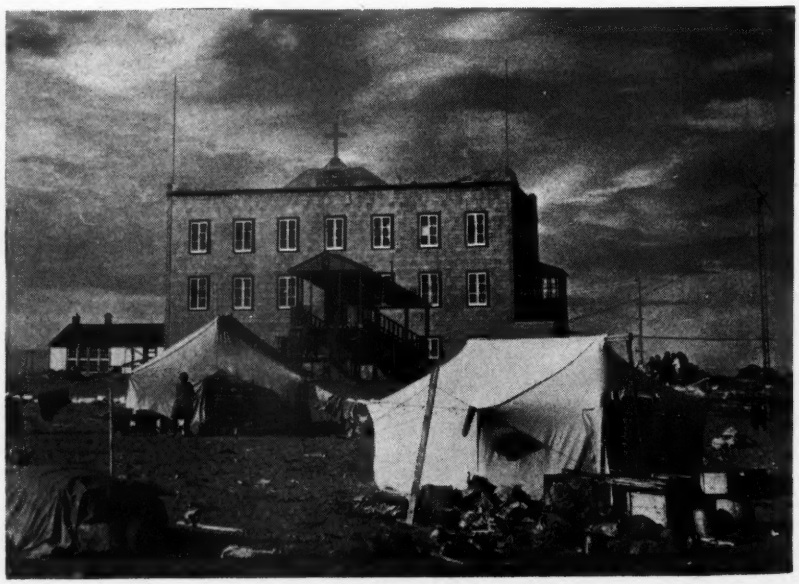
From the information gathered places had been laid for the increased aid program which was to have been furthered on this year's patrol arrangements. The clinical follow-up of the 1946 survey was to include special attention to those classed as family contacts. Nursing stations are being set up at several key points and a comprehensive educational scheme is being inaugurated covering the field of preventive medicine, including prenatal care and the auxiliary feeding of infants. In this connection the doctors last year found a scarcity of children under the age of three years among the Eskimoes and it is probable that about fifty per cent of all deaths occur during these years. Since love of children is strong among the natives, the examiners could only attribute the high infant mortality rate to malnutrition and ignorance of infant care. The Eskimoes learn quickly and it is hoped that distribution of pamphlets on prenatal and infant care, in syllabic writing, plus their usual eagerness to co-operate with the doctors, will aid in correcting this situation.

Large-Scale Chest Survey

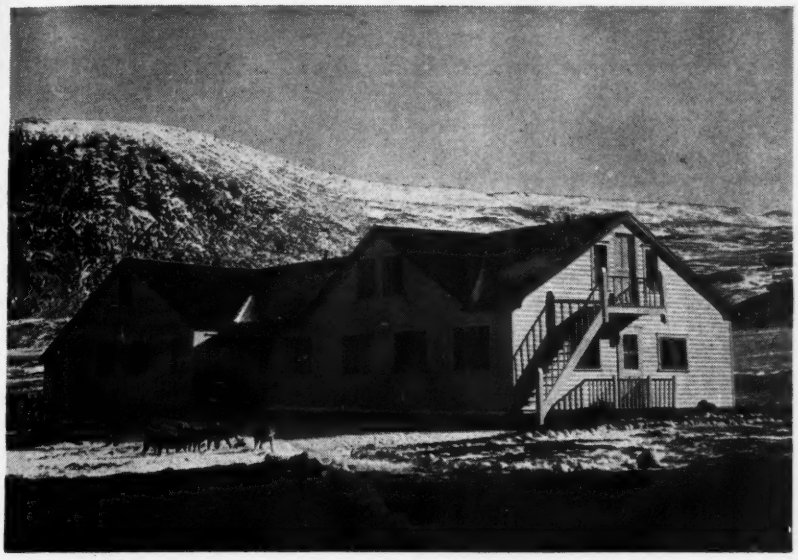
This most extensive medical examination ever given the nomads of the north brought to light many facts of interest and value. Cases of *healed tuberculous bones* were discovered, demonstrating that the Eskimo can build up a degree of immunity to white men's diseases. Cancer and nervous, mental and heart diseases, increasingly frequent in the white man's world, *were not to be found.* Fractured bones were common, gangrene from frostbite appeared occasionally, but gunshot wounds, for a people who live by the provender of their high-powered rifles, were remarkably rare. The most common cause of death among adults was drowning. Strangely enough, severe rheumatic conditions were not seen nor were there cases of appendicitis or venereal disease. *Not one case* of infected sore throat or tonsilitis was encountered.

As a result of the large-scale chest survey undertaken by the Department, there is now on file a complete card index and chest plate of every one of the 1,547 examined. This places the Department in a better position to organize any necessary preventive program. Dr. H. W. Lewis,* medical superintendent for the Eastern Arctic, was in charge of medical aspects of the *Nascopie's* trip, and with him to handle the complete x-ray equipment on board

**Dr. H. W. Lewis was superintendent for a number of years of the Saskatoon City Hospital.*



Ste. Therese Hospital at Chesterfield Inlet, North West Territories. Note the Eskimo tents in the foreground.



St. Luke's Mission Hospital at Pangnirtung, one of the "Nascopie's" ports of call.

were x-ray specialists, and his daughter, Margaret, who acted as technician. Results of the 1,547 x-rays taken revealed about five per cent with active tuberculosis and another five per cent in whom the disease had apparently *healed spontaneously without treatment.*

At the fifteen posts visited by the medical group the *Nascopie's* little saloon was crowded with Eskimoes awaiting their turn at the dentist's chair. At these remote outposts the dental officer on board yanked decayed bicuspids and yellowed molars from long-swollen jaws, although it was found that the general condition of the natives' teeth was sound. Eyes are tremendously important to a people who live by hunting and clothe themselves by their own sewing. Work on Eskimo vision during last year's trip was continued by the Canadian National Institute for the Blind in co-operation with the federal department. Today many an Eskimo is peering along the sights of his rifle through lenses ground in Montreal or Toronto. The Institute eye specialists found that vision among the Eskimoes was generally good, with only 128 natives out of the 1,547 examined requiring glasses, whereas out of the 39 whites tested 29 needed glasses. By arrangement between the Institute and the department all glasses are supplied free to the Eskimo by the government. The eye specialists were rewarded in many instances on the spot. Many an old native woman who had ruined her eyesight sewing in a dark igloo by the light of a seal-oil lamp cried for joy when she could see again.

It was hoped to have the inoculation program, started three years ago, completed this year. The program guards against recurrence of epidemics of whooping cough, smallpox, diphtheria and typhoid, which were aggravated by the abnormal movement of population in the north during the war years.

When the "Nascopie" foundered she was making her 33rd annual trip carrying supplies to outpost stations of police, radio operators, traders, missionaries and doctors. Two hundred white persons and from five to six thousand Eskimoes, comprising some forty outposts, depended on the "Nascopie" for replenishment of their supplies. Only four of these had been serviced. While all passengers and crew were removed without mishap, a great deal of the cargo was lost. Arrangements have been made to organize aircraft and ships to carry on with the work of the "Nascopie" and to transport supplies to as many posts as possible before the winter season begins.

It is most unfortunate that the "Neophyte", a sister ship carrying supplies to those posts not on the course of the "Nascopie", has also been grounded and abandoned.

Important Discussions Planned for C.H.C. October Meeting

A particularly helpful program is being planned for the Canadian Hospital Council meeting to be held in Winnipeg, October 16 to 18.

As the Council really constitutes a parliament of the hospitals from coast to coast, a program is being shaped which relates in the main to the formulation of national policies rather than to details of administrative procedure.

With this objective in mind, there will be very few addresses as such. The three-day session will be allocated to periods for the discussion of key subjects. After an initial introduction and general discussion by delegates, the crystallization of views into policies will be encouraged. Among the topics which will receive special consideration are the present shortage of nurses and other personnel and the necessary steps for its correction; personnel relationships, unionization, recognition of bargaining agents and related aspects; hospital finance with special reference to government patients and the trends for the future in meeting capital and operating costs; voluntary hospital and medical plans; hospital care for rural areas; the future of the voluntary hospital; progress in accounting; pension plans; the present situation in respect to hospital construction; and such other topics as time permits. It is planned to hold a Council dinner on the night of October 18th.

It is again stressed that all interested in any of the many phases of hospital work will be welcome at these conferences. Those desiring reservations at the Royal Alexandra hotel should write to the management AT ONCE as available accommodation is being rapidly taken up.

The Importance of CLINICAL PATHOLOGY *to Modern Medicine*

DR. D. B. ROXBURGH,
Medical Superintendent and Pathologist, St. Joseph's Hospital, Victoria, B.C.

THE term "pathology" is not always clearly interpreted. It is not generally understood by the laity and often misused by the doctor. "Pathology" comes from the Greek *pathos* — "suffering", and *logia*—"study". It is defined as the branch of medical science which deals with disease in all its relations, especially with its nature and the functional and material changes caused by it. Pathology therefore is the study of disease. What we call medicine and surgery are the applications of pathology. I have heard doctors, when they are examining an organ, say that "there is no pathology present". What they mean, of course, is that there is no lesion present.

In the larger centres, and notably in Great Britain, there is a distinction drawn between the pathologist and the clinical pathologist. The pathologist is a morbid anatomist; he works almost exclusively with tissues, making gross and microscopic diagnosis. More often than not he is a teacher in a medical school. On the other hand, the clinical pathologist is a man who is equipped to direct the work of a clinical laboratory, usually in a hospital. In this country the clinical pathologist usually fills both roles. He is trained in gross and microscopic tissue diagnosis, clinical bacteriology, clinical chemistry, haematology, serology and parasitology. One might define a clinical pathologist as anyone with a medical degree, whose subsequent training and practice make him proficient in any medical laboratory specialty. In short, everyone who studies or investigates materials derived from patients deals with clinical material, and if he is qualified in any of the several fields of pathology, he is a clinical pathologist.

The clinical pathologist owes a great debt to the physiologist and biochemist — the research work of yesterday so often provides the methods for the laboratory procedures of today. The newer methods for estimating chemical changes in the blood, developed by active physiologic chemists, constitute many diagnostic methods that are of daily use in the clinical laboratory. The same debt is owing to the closely related investigators in serology and immunology. In applying the physiologist's methods to the study of the patient, the clinical pathologist becomes a clinician.

The pathologist may not, and should not, assume responsibility for the care of the patient, but as a diagnostician he should always feel a grave responsibility to the patient, for on his accurate observations depend the diagnosis of the disease and the plan of treatment, surgical and medical. His attitude towards his colleagues should be that of a consultant. Although it may be sufficient merely to give a report of observations, the alert and conscientious clinical pathologist should be able to interpret those observations as applied to the particular case in hand. If his opinion is sound and his conclusions are accurate, he will command the respect of the surgeon and clinician who has sought his advice.

Clinical pathology is a specialty of medicine and to practise clinical pathology is to practise medicine. Therefore a clinical pathologist must be a graduate in medicine and duly licensed to practise. In addition he should have specialized in clinical pathology, bacteriology, pathology, chemistry and other allied subjects for at least *three years*. The recent graduate or the general practitioner is no more qualified to act as the director of a clinical laboratory than he is to pose as a specialist in radiology or ear, nose and throat.

It has been my firm conviction throughout a long period of training and many years of experience that a successful clinical pathologist must be primarily a skilful technician. It is only after years of practice that one becomes sufficiently familiar with technical procedures to be able to assist, correct or advise others. The pathologist is distinctly handicapped when he is asked to interpret smears of different types, and tissue sections that are poorly prepared.

A good technician is invaluable to the clinical pathologist. He or she must possess a rather formidable list of natural qualifications. Among them, in my opinion, intelligence ranks first. Then follows a gift for attention to detail, accuracy, deftness

Pathology is the study of disease in all its relations. What we call medicine and surgery are the applications of pathology.

From an address given at the British Columbia Hospitals Convention, 1946.

in handling instruments of precision, patience, scientific honesty, and a system of philosophy which embraces willingness to work long hours for very moderate wages. To all of these qualifications must be added a sincere regard for the welfare of the sick.

The modern clinical pathologist has still another role. Whether or not he desires the responsibility, he usually finds that he must be an executive. As director of a laboratory he must employ technicians, purchase supplies and apparatus, keep accurate records and files, and make charges for services rendered. He must be as much of a businessman as a physician can be, and often many of the details of a hospital, institution or group will intimately dovetail with the actual business of running the clinical laboratory.

When the diagnostic laboratory, first developed in the physician's office, was transferred to the hospital, the results were far from satisfactory. The reasons for this were to be found in inadequately trained personnel, both professional and technical, in attempts at complicated procedures without proper equipment, and last but not least, in lack of proper co-ordination between the laboratory and the clinical departments. During the past several decades these conditions have greatly improved. The American and Canadian Societies of Medical Technologists have established high standards of proficiency for certification of technicians. While there is still a scarcity of clinical pathologists, many men have chosen this special field and it can be expected that many more will follow as the law of demand in relation to supply is exercised.

There has been a growing tendency in the practice of medicine for the past twenty years to replace clinical impressions by accurate precision measurements — if not to replace clinical impressions entirely, at least to check them. In many places and under many conditions clinicians have forgotten to use their own powers of observation and have made use of the laboratory even to a ridiculous extent. However, the laboratory and its directors have served time and time again to aid the physician by carefully verifying his observations with instruments and by application of methods of precision, so that in the end the clinician has realized his own limitations — a very much worthwhile result.

The laboratory director must not assume that all laboratory findings are infallible or, even when they are absolutely true, that they are necessarily the only factors in diagnosis.

The modern laboratory performs a great variety of procedures and determinations, which result in one or more of the following:

(1) The confirmation of a diagnosis of which the clinician might have had some suspicion;

(2) the diagnosis of a condition which the clinician did not suspect;

(3) the exclusion of a diagnosis of which the clinician was suspicious;

(4) the confirmation of positive clinical diagnosis;

(5) the correction of a clinical diagnosis;

(6) the recognition of accessory pathologic conditions;

(7) the determination of stages in the course of a disease;

(8) the determination of the physical status of the patient preparatory to possible operation, or other treatment;

(9) assistance in determining the extent of operations;

(10) determination of data for preoperative, operative and post-operative prognosis;

(11) assistance in determining causes and modes of surgical infections;

(12) determination of the cause of death in non-surgical and surgical cases.

In the field of heamatology the type and degree of anaemia can be positively established only after numerous blood studies have been performed. Blood transfusions form a part of everyday practice. Today, I trust, there is not a single physician who would authorize a blood transfusion without first calling on the clinical laboratory to determine if the blood of the donor and the blood of the patient were compatible.

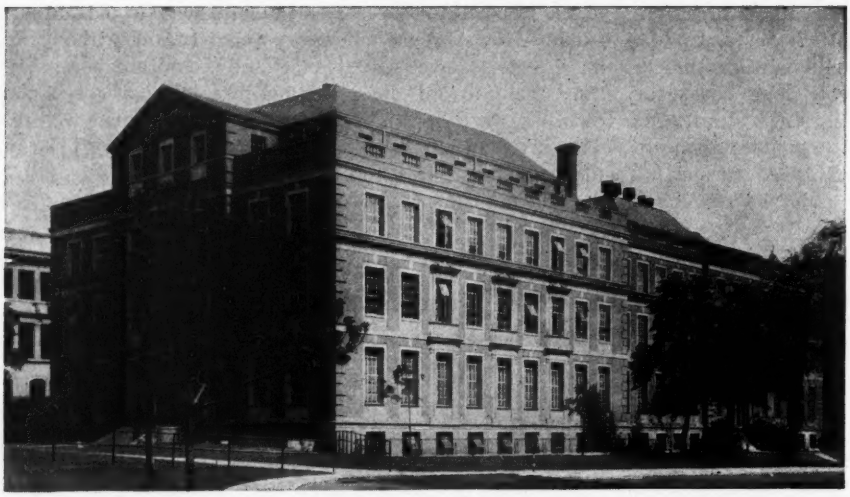
In the field of clinical bacteriology many diseases cannot be diagnosed without the aid of the clinical laboratory. Diseases, such as diphtheria, tuberculosis, typhoid, dysentery and meningitis, present sufficiently characteristic signs and symptoms to lead to a correct clinical diagnosis when they are well established and advanced. But in the early stages, when appropriate treatment is of most value, a correct diagnosis is only possible by laboratory methods.

Is there a clinician, however expert, who can diagnose with even a rough approximation of accuracy, the disease of syphilis, without the aid of the laboratory? Is it possible intelligently to give treatment in such cases without repeated examinations by the clinical pathologist? The answer is so apparent that the matter for discussion these days is not whether serologic tests should be employed, but what kind of tests should be employed; and here again the pathologist must answer the question.

The clinical pathologist is asked to perform a rather wide variety of procedures to determine the level or concentration of different substances in the blood. It is doubtful if one should consider pregnancy a disease. However, it must be diagnosed, although clinicians have scientifically studied the signs of pregnancy for more than 5,000 years. Comparatively recently devised and simple laboratory tests can detect pregnancy earlier and more accurately than any set of clinical observations yet perfected.

Modern surgeons do not think of considering a diagnosis of tissue as final until a competent pathologist has passed on it, and the injustice the surgeon would do his patient if he failed to take advantage of such consultation would not only be a reflection on his own judgment but might result in a judgment against him in a civil court.

In the field of histopathology, which is the microscopic diagnosis of tissues, the opinion of the pathologist is rarely if ever contested by the surgeon. Modern surgeons do not think of considering a diagnosis of



School of Hygiene, University of Toronto

Headquarters for the new graduate course in Hospital Administration which will commence September 22nd. This will be a course of twenty-one months. The first nine will be at the University and at various hospitals in Toronto and the remaining twelve months will be in the form of an administrative internship in a selected hospital under the direction of the administrator. D.V.A. educational gratuities may be utilized and it is likely that several bursaries may be available for worthy students taking the course. Enquiries may be made of Dr. R. D. Defries, Director of the School of Hygiene, or of Dr. Harvey Agnew, Head of the Department.

tissue as final until a competent pathologist has passed on it, and the injustice the surgeon would do his patient if he failed to take advantage of such consultation would not only be a reflection on his own judgment but might result in a judgment against him in a civil court. The diagnosis of tissues obtained at operation, and the diagnosis of tissues obtained at post-mortem, have furnished the preliminary knowledge which, advanced by bacteriologists and chemists, is gradually pushing into the yet unsolved question of cancer. This is probably the laboratory man's greatest problem today, and the solving of it must, by the very nature of the disease, be undertaken by him. Due to improved laboratory methods a pathologist can advise a surgeon regarding a microscopic diagnosis within three or four minutes after the tissue is removed from the patient. The nature and extent of the balance of the operation is frequently decided after this information is obtained. The conscientious and progressive surgeon is constantly trying to correlate the signs and symptoms of the patient and the naked-eye appearance of the tissue with the microscopic findings recorded by the pathologist.

Post-Mortems

Much of what is known today about the cause, nature and effect of disease has been learned in the post-mortem room. Post-mortems should always be conducted with a two-fold purpose. First, to establish clearly the principal and contributing causes of death. Secondly, to learn all one can about disease processes, the efficacy or non-efficacy of various medical and surgical treatments, with a view of rendering more intelligent aid to the living. Vital statistics form a very important part of medical knowledge. Any pathologist, and I would hope many practitioners, would tell you that a clinical cause of death has often to be greatly modified or entirely changed after a post-mortem examination is made, for purposes of completing the death certificate. It therefore follows that in those cases where a post-mortem examination is not made the official record of the cause of death may not be an accurate one.

The clinical pathologist is frequently the only man in a community with the necessary training, experience and facilities, who can assist the coroner and police in medico-legal problems. He is often called upon to perform post-mortem examinations in cases of sudden death where the circumstances suggest other than natural causes. He may be asked to match hairs, identify exudates or secretions, and group bloods. He may be required to carry out very delicate and painstaking tests to determine the nature of stains and smears on important court exhibits. Here the technique can rarely be left to an assistant or technician. There is too much at stake.

In public health work the clinical pathologist has reigned supreme, basing his fight on a solid foundation of bacteriology, chemistry and pathology. Laboratory methods are used to prove the safeness of drinking water and of preserved foods, and the thoroughness of milk pasteurization. In hospitals it may become necessary to determine the efficiency of sterilization methods and asceptic techniques. Here again the laboratory provides the answer.

Interpretation

The laboratory director must not assume that all laboratory findings are infallible or, even when they are absolutely true, that they are necessarily the only factors in diagnosis. There is probably no such thing as absolute precision. The clinical pathologist must choose methods which are subject to the least inevitable error commensurate with practicability. Often the clinical importance of the results or the significance of the findings do not warrant the use of more costly and precise methods in routine work; but there is no excuse for the laboratory worker who, when two or more methods of more or less equal practicability are available, does not choose the most accurate one. One must be constantly alert to the sources of error. Technical training to a high degree of proficiency, the use of accurately calibrated apparatus, and the choosing of methods with the smallest inherent source of error will usually provide dependable laboratory reports.

In the interpretation of laboratory results it is frequently necessary for the clinical pathologist to point out to the clinician that what he accepts as a normal value for any procedure or measurement is in reality a group normal. We do not know the normals for any individual. Thus the normals are given as a range. The normal red blood cell count for man is four to six million, with an average of five million; the normal level for sugar in the blood is eighty to one hundred and twenty milligrams per hundred c.c., with an average of one hundred; and the normal basal metabolic rate is minus ten to plus ten, with the greatest number of individuals having a normal of zero.

The Small Hospital

How can the hospital that is too small to support a resident or full-time pathologist provide some measure of service in clinical pathology? This is a difficult problem and one not easily solved. A scheme which has been followed successfully in many communities is for a pathologist to serve two or more hospitals on a part-time basis. Under his supervision a clinical laboratory can be designed and organized. He assumes responsibility for the efficiency of the technicians, and will likely make his headquarters in the larger centre, paying regular visits to the small laboratories. These smaller laboratories could draw on the larger central laboratory for standard reagents and bacteriological media and apparatus. When apparatus and equipment is purchased by large orders, a very substantial discount is usually made. Standard reagents and media are generally costly to prepare in small quantities, while larger amounts can be made at very little additional cost. Specimens from the smaller laboratory can be forwarded to the main laboratory for examinations that require more elaborate facilities.

The London System

It has been my privilege to see and study the administration of the London County Council pathologic service. This involves many hospitals and has been organized on the following basis: In each of the nine so-called group laboratories situated in strategically placed hospitals throughout Greater London there is at least one well-qualified pathologist. In some, there are two or more. In addition there is an efficient technical and clerical staff. The group laboratory serves not only the hospital in which it is situated but two or three smaller hospitals within reasonable proximity. The smaller laboratories are staffed by technicians only who come directly under the supervision of the clinical pathologist in the group laboratory. All laboratory equipment, reagents and supplies are distributed from one main centre. Although all the pathologists have a very excellent general training, each one has made a further specialty of one of the subdivisions of clinical pathology. He is especially equipped and trained to deal with more elaborate and advanced clinical laboratory procedures in one or another branch. Thus cases can be referred from one group laboratory to another. The entire organization comes under the management of the Chief Pathologist.

Where hospitals are separated by many miles, as is the situation in most parts of British Columbia, the service one pathologist could give to several hospitals would be less than the optimum expected where geographical factors play a much smaller part. Nevertheless, I would suggest that some measure of pathologic service is considerably better than none, and the several hospitals in this organization without pathologic service should give serious consideration to some of the matters which have been touched upon in this talk.

Committee Urges More Indian Hospitals

The joint Parliamentary Committee on Indian Affairs has recommended to the House of Commons the setting up of a separate Indian Affairs Department with civil service preference for Indians on its staff.

Among the other recommendations of this Committee are:

The erection of central hospitals in northern agencies with nursing substations in remote areas.

Statutory provision for the care of aged, infirm or blind Indians.

Establishment of an Indian claims commission to inquire into the terms of all Indian treaties.

The question of enfranchisement to be left for further consideration next year.

The Indian Affairs Branch take immediate steps to remove non-Indians from reservations consistent with the wishes of the band concerned.

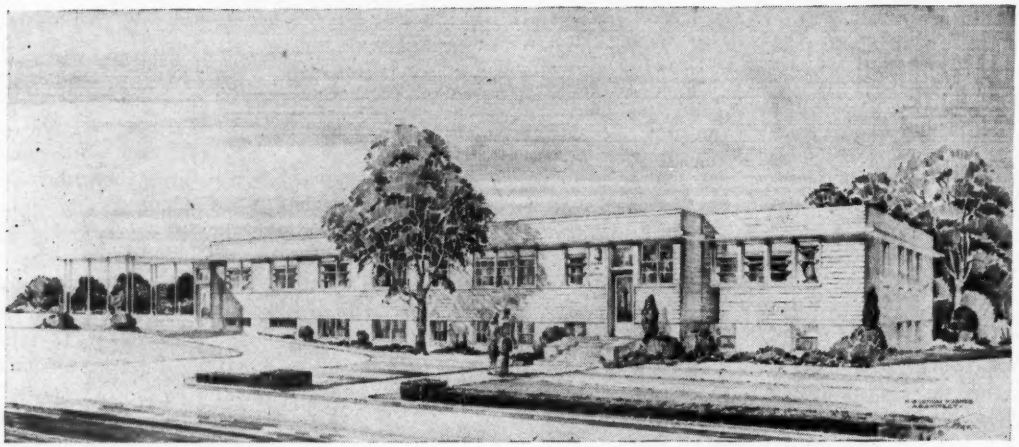
Decentralization of the Indian administration with regional directors for various areas.

Widening of the competition field, now confined to local districts, for appointments as agents.

Abolition of the "permanent quota" for the Indian administrative staff.

As an alternative to the proposal to establish a separate department, the committee proposes the appointment of an Indian commissioner with deputy-ministerial rank. The commissioner would have two assistant commissioners, one of whom would be of Indian descent.

The committee also recommended appointment of the committee again next session to consider "long overdue" amendments to the Indian Act. Chairman of this committee is Don Brown (L. Essex West).



HOSPITAL and HEALTH CENTRE Units Planned for RURAL Areas

Plans by
H. Gordon Hughes, Chief,
Hospital Design Division,
Department of National Health and Welfare

A PRACTICAL brochure entitled *Plans for Canada's Rural Health* has been issued by the Hospital Design Division of the Department of National Health and Welfare. This small publication is designed to meet two needs — that of the community desiring to build a small 6- or 8-bed health centre, and that wishing to erect a hospital of 20 to 30 active treatment beds or one accommodating 30 to 60 beds. Plans for these units are reproduced in the booklet, together with some descriptive text.

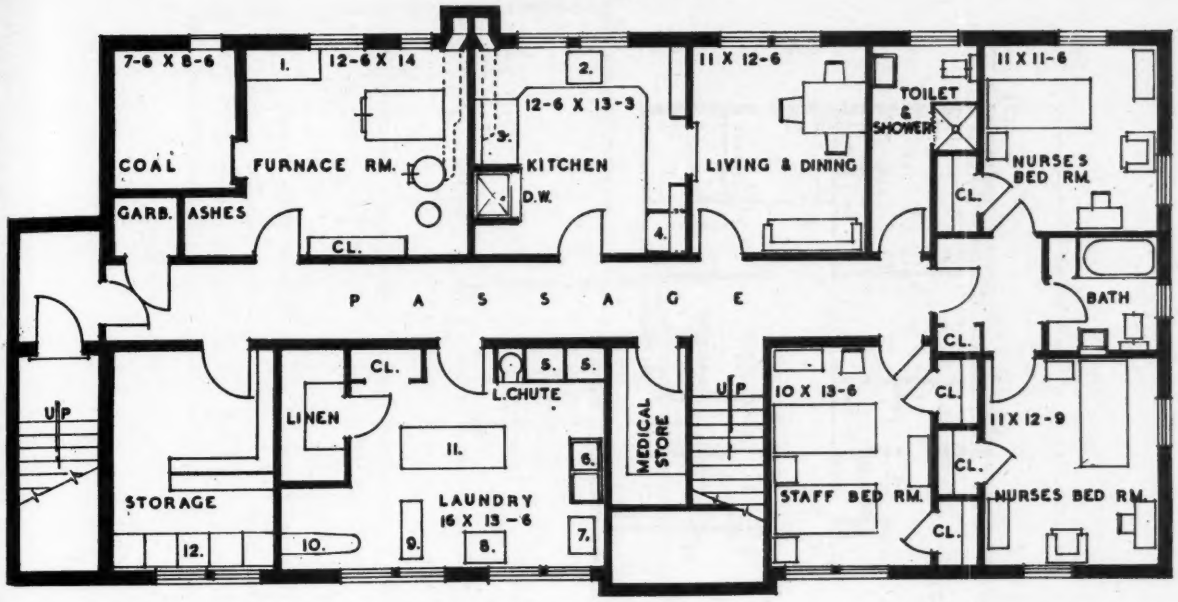
Specifications are not given nor is there an estimate as to the range of costs. It is obvious that costs will vary, depending upon the type of material used, availability of materials in the area, and the prevailing level of costs at the time at which construction is undertaken.

These sketches have been made with the object of providing modern and adequate facilities, but without undue expense. The different facilities considered desirable in a hospital or nursing unit are indicated in the layout, to the extent to which they should be considered for a unit of a given size. It is pointed out that the drawings reproduced are basic plans only and should be altered to meet particular local conditions. Working drawings and specifications should be prepared locally.

In the 6- and 8-bed health centre layouts there is a well-proportioned case room because there may readily be more obstetrical patients than other types of cases. The 6-bed unit does not contain any operating room, it being assumed that surgical work would be referred elsewhere and emergency work could be handled in the case room. An emergency room of adequate proportions is included in the 8-bed unit. The doctor in charge of such a health centre will have a room for examinations and in the case of the 8-bed unit there will be an office for the sanitary inspector. The public health nurse will have her headquarters in the unit. The demonstration and lecture rooms are omitted in the 6-bed unit.

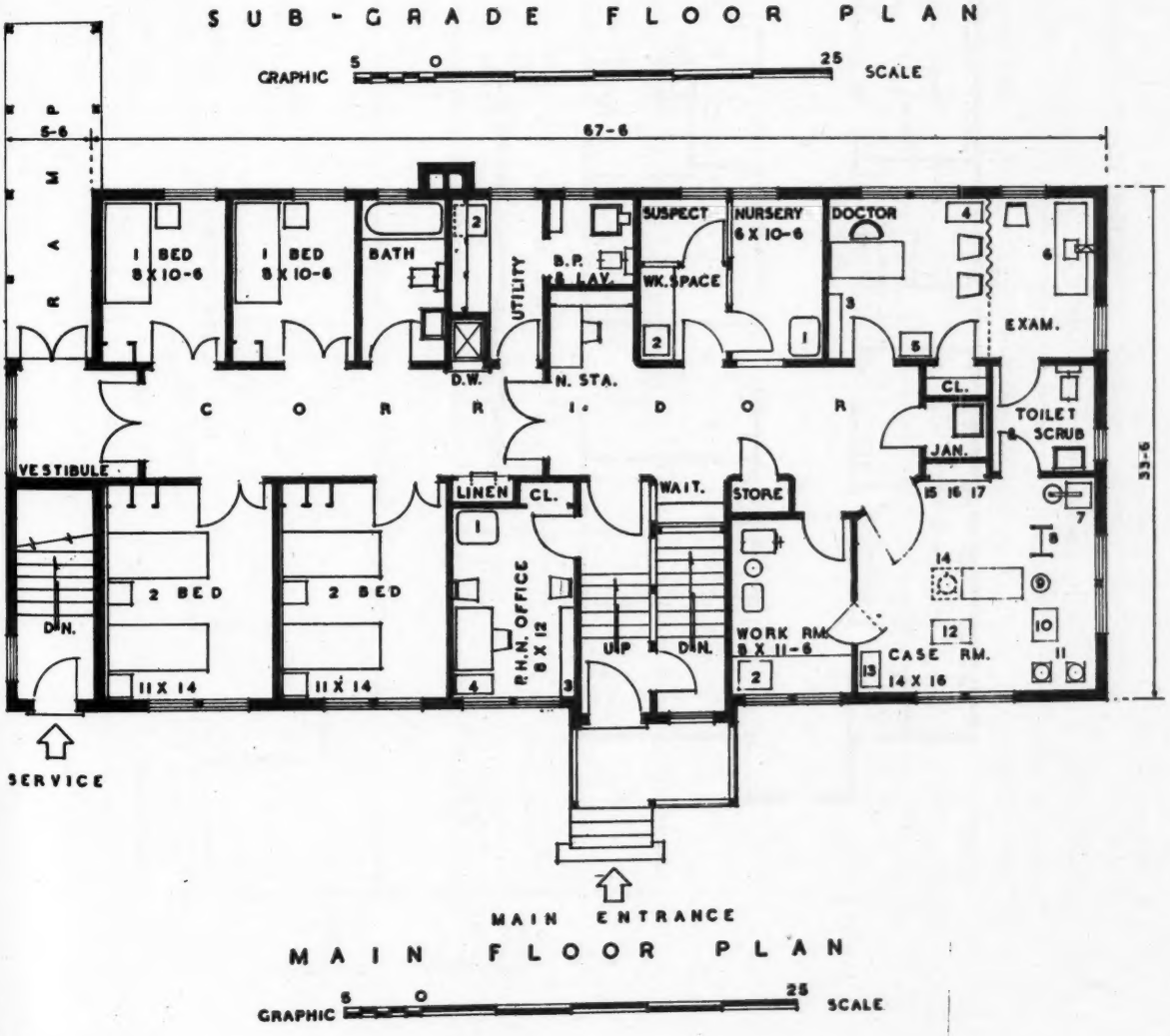
Copies of the booklet may be obtained from the various provincial health departments or directly from the Hospital Design Division, Department of National Health and Welfare, Jackson Building, Ottawa.

6-Bed Health Centre



SUB-GRADE FLOOR PLAN

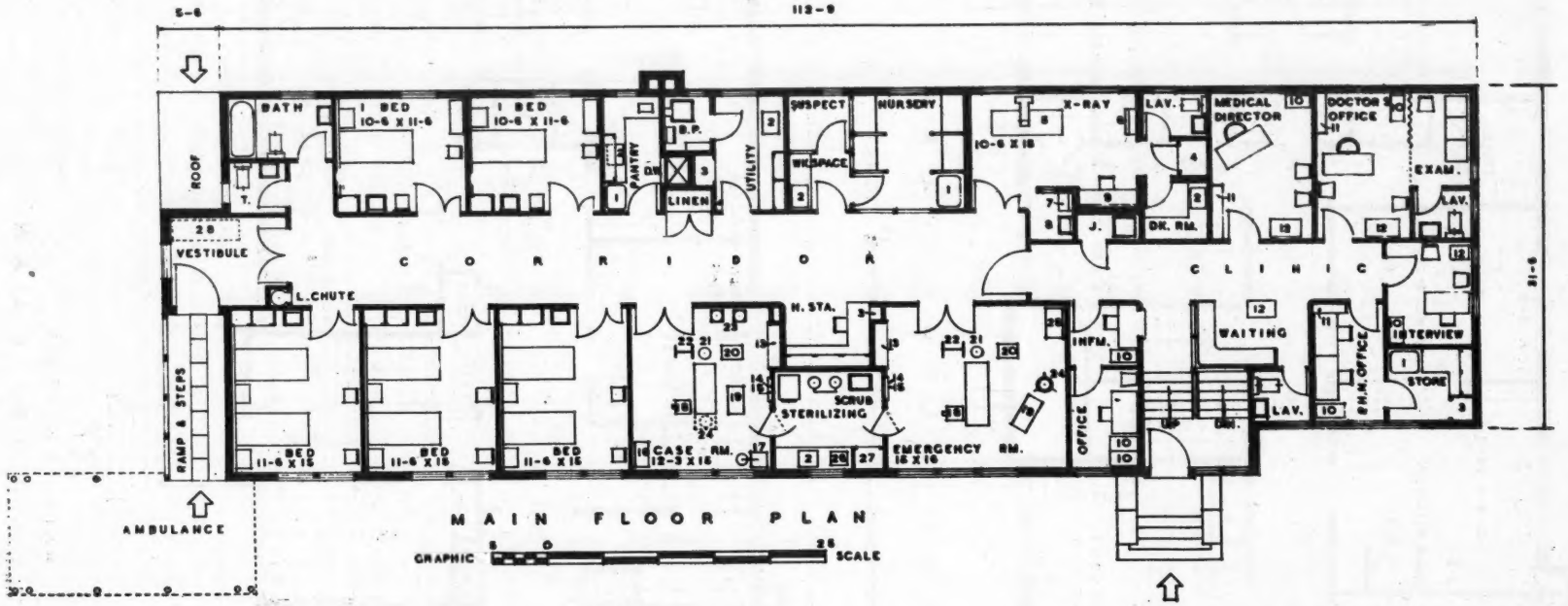
GRAPHIC 5 0 25 SCALE



MAIN FLOOR PLAN

GRAPHIC 5 0 25 SCALE

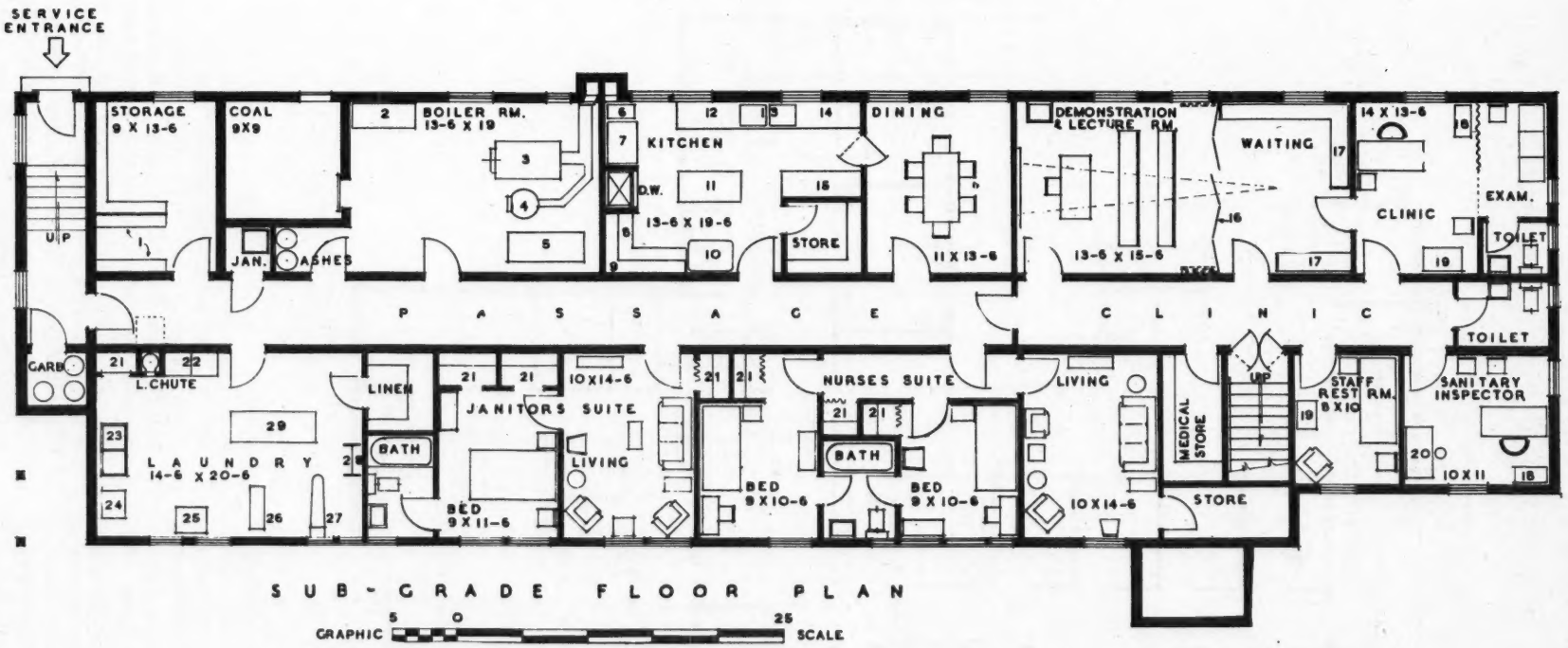
8-Bed Health Centre



LEGEND

1. Refrigerator
2. Sink
3. Closet
4. Film Closet, Lead Lined
5. Radiographic & Fluoroscopic Unit
6. Cassette Changer
7. Control Unit
8. Barium Sink
9. Table with Film Filing Under and Wall Mounted View Box
10. File Cabinet
11. Bookcase
12. Table
13. Instrument Cabinet
14. Clock with Interval Timer
15. Recessed View Box
16. Heated Bassinet
17. Portable Emergency Light
18. Mayo Table
19. Instrument Table
20. Anaesthetist's Table
21. Anaesthetist's Stool
22. Anaesthesia Unit
23. Single Basin Stand
24. Kick Basin
25. Pack Table

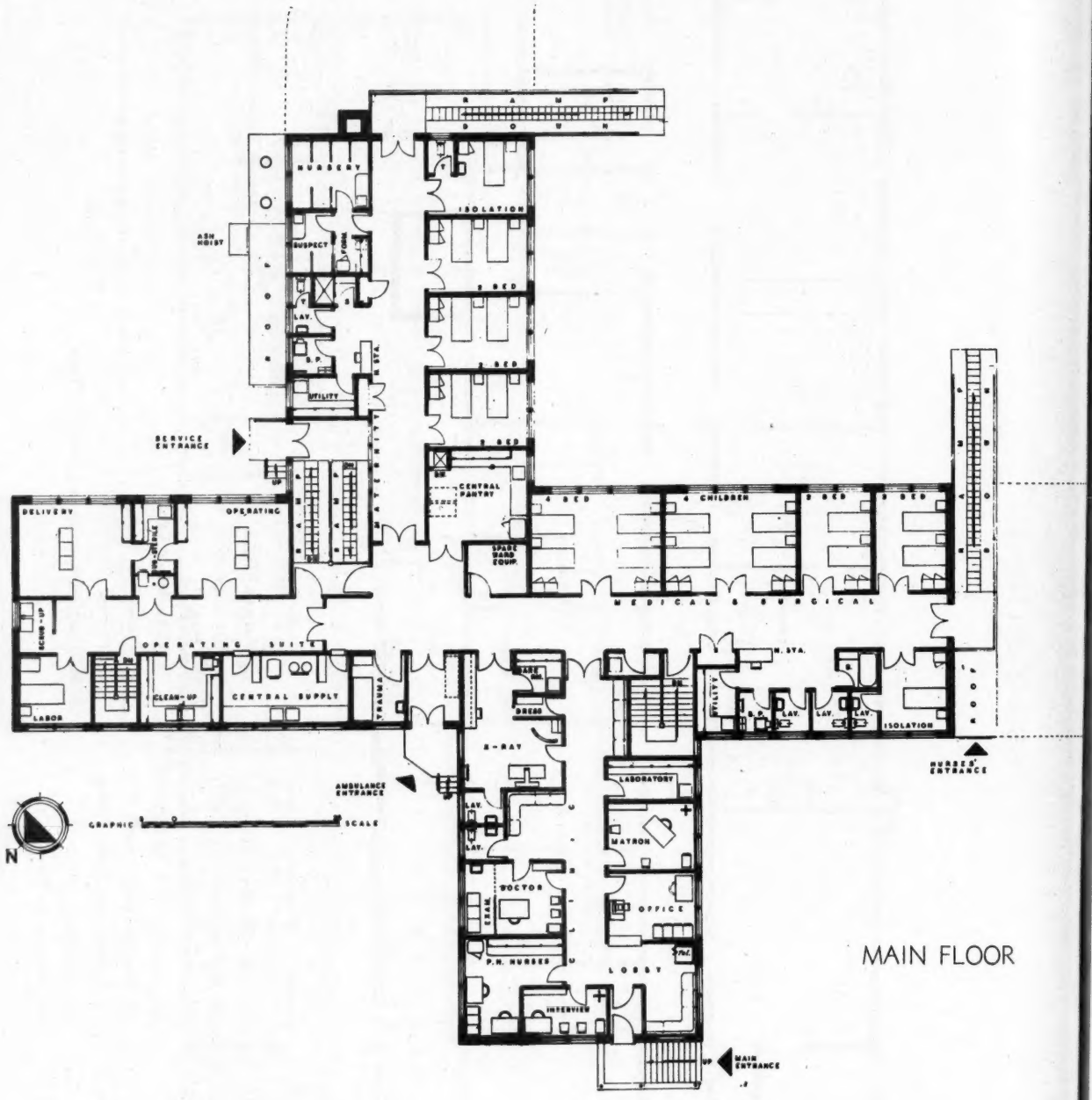
8-Bed Health Centre



LEGEND

1. Removable Shelving
2. Work Bench
3. Furnace
4. Jacket Heater
5. Hot Water Tank
6. Range Coal
7. Range
8. Tray Set-up Counter
9. Dish Storage Cupboard
10. Refrigerator
11. Cook's Table
12. Counter for Clean Dishes
13. Double-compartment Sink
14. Counter for Dirty Dishes
15. Serving Counter
16. Folding Doors
17. Built-in Bench
18. File Cabinet
19. Table
20. Draughting Table
21. Closet
22. Sorting Bins
23. Double-compartment Laundry Tubs
24. Combined Washing Machine and Extractor
25. Electric Drier
26. Electric Ironer
27. Ironing Board
28. Uniform Rack
29. Table

20-30 Bed Active Treatment Hospital



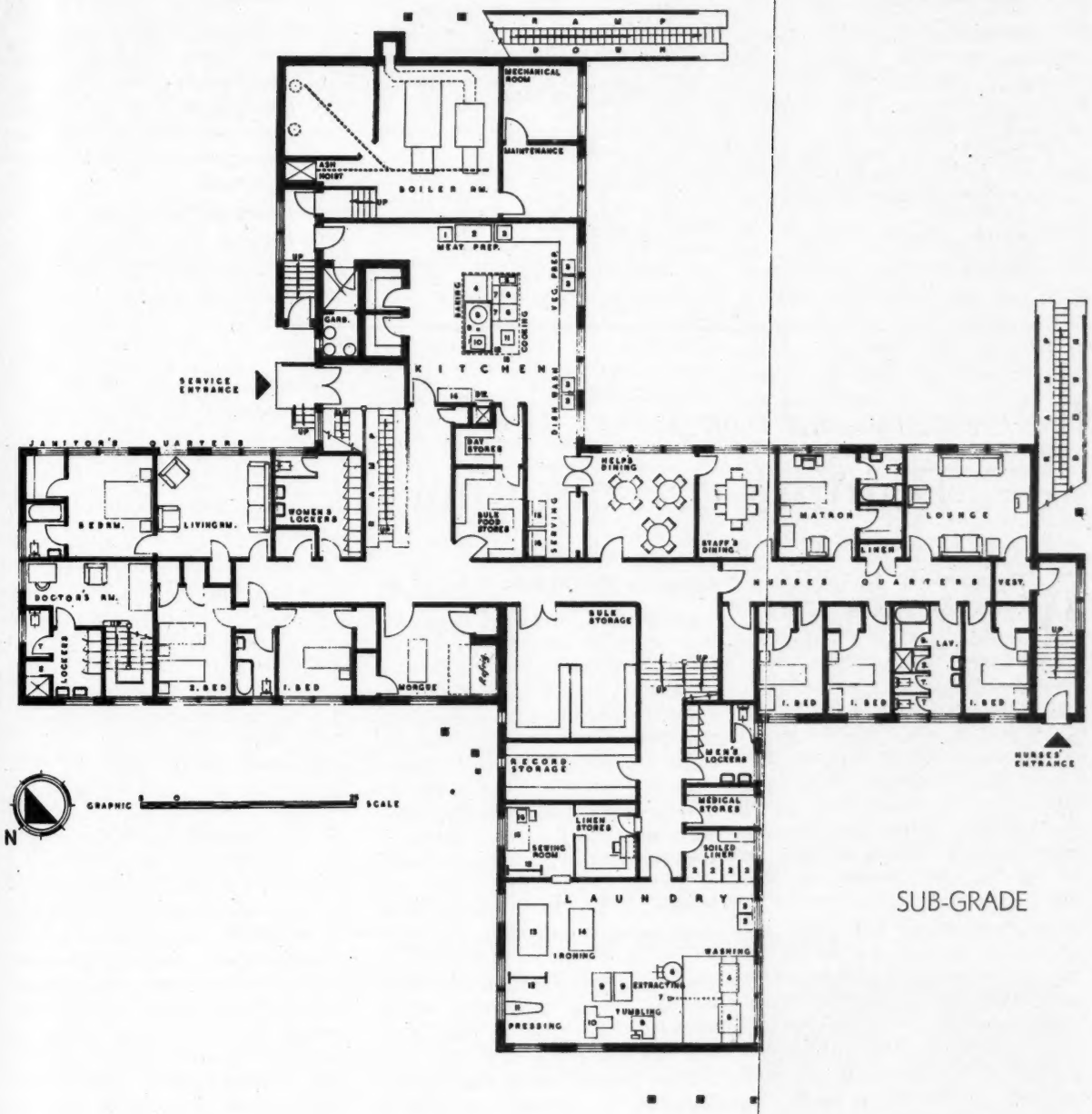
MAIN FLOOR

In the above plan flexibility, economy and utility are the keynotes. As the layout shows, the nursing areas and adjunct facilities are on the main floor while the subgrade area is utilized for basic services. Four nurses live in and the remainder would live elsewhere. However, quarters for all could be provided by building a penthouse over the operating suite. Note that the doctors' rest room and lockers are placed directly below the operating suite to help make the building compact.

Delivery and labor rooms are in the same suite as the operating room. Although in large hospitals it is desirable to have surgery and obstetrics separated, it is probable that the chance of cross infection will be small in a unit such as this, where the operating suite is not in continual use. This arrangement saves considerably on cost.

A trauma or emergency room is located next to the ambulance entrance. This facilitates emergency care and the room can be used as an

20-30 Bed Active Treatment Hospital



SUB-GRADE

observation room as well. It is possible that a hospital of this size would require space for two or more doctors' offices.

As in the case of the smaller units, there is included in the administrative wing an office for the public health nurse, a room for interviews and an office for the doctor. This plan, as drawn, does not include a demonstration and lecture room.

The subgrade floor plan shows space for the doctors' lounge beneath the operating room and a stairway connecting these rooms. There is no need for an elevator in the building as the combination of ramp and a stair from the ramp elevation permits easy transportation of goods and the removal of bodies.

The laundry is at a lower level than the general sub-grade floor, an arrangement which assists in the dissipation of the heat generated there. The boiler room is also on a lower level than the sub-grade floor. Ample storage space is provided in the plan and it may be noted that there is a private entrance for nurses.

Legends for Six-Bed Rural Health Centre

(See page 35)

Sub-Grade Plan

1. *Work Bench*
2. *Sink*
3. *Range*
4. *Refrigerator*
5. *Sorting Bins*
6. *Two-compartment Laundry Tubs*
7. *Combined Washing Machine and Extractor*
8. *Electric Drier*
9. *Electric Ironer*
10. *Ironing Board*
11. *Table*
12. *Vegetable Storage Bins*

Main Floor Plan

1. *Refrigerator*
2. *Sink*
3. *Bookcase*
4. *File Cabinet*
5. *Table*
6. *Examining Table and Fluoroscope*
7. *Portable Emergency Light*
8. *Anaesthesia Unit*
9. *Anaesthetist's Stool*
10. *Anaesthetist's Table*
11. *Single Basin Stand*
12. *Instrument Table*
13. *Heated Bassinet*
14. *Kick Basin*
15. *Instrument Cabinet*
16. *Recessed View Box*
17. *Clock with Interval Timer*

Preliminary and Concurrent Training of Personnel

Sister Patricia, O.S.B., F.A.C.H.A.,

Administrator, St. Mary's Hospital, Duluth, Minn.

WHATEVER its motivation, employee training is an accepted fact in the present-day business field. Reports show that it has proved its financial value. No matter how plentiful the supply of workers or how rigid the policy of selection, progressive concerns believe that employees doing any kind of work perform their duties more efficiently when they have received training. Today training on the job has itself become big business.

Hospitals, in general, have not profited by the example set by industry in this matter. If they have learned the lesson, they have not always applied it. Consequently they continue to face the serious problem of securing and retaining qualified workers necessary for the proper operation of the institution. Today personnel turnover is higher than at any other time, and the prediction for tomorrow is none too bright. On-the-job training may hold some part of the answer.

Such training programs pertain especially to the duties of the non-professional employees. In general, hospitals have well-regulated educational programs for the professional group, residents, interns, nurses, and the various staff members of the diagnostic and therapeutic departments. Despite great advances in hospital administration in other lines, we must admit that our non-professional employees have been allowed to remain the forgotten men and women. They have learned their tasks by watching other employees, on the same level as themselves, do the job; a method of tutelage which no alert business executive would tolerate. Yet hospitals rank sixth among the nation's industries.

That hospitals have thus ignored the scientific approach to personnel training is amply borne out by the findings of a survey of hospital training programs. I quote: ". . . most hospitals do not (1) give any general formal training to employees concerning hospital policies; (2) conduct preliminary classes or conferences for new employees before assignment to duty; (3) assign one person to install and administer the formal training given in any instance; (4) distribute employees' handbooks or manuals which contain information about the organization, departmental functions and the particular duties of the job to be performed; or (5) issue series of specific printed instruction sheets for all situations."*

All of these practices are prevalent in industry and business.

Training a Motivating Force

Some one has said that personnel is the heart of management and that education and training are the motivating force of sound management. If this is true, a satisfactory program of training must begin at the top and operate at all levels. The administration must recognize the need for training and recognize also that attitudes, leadership and experience are of paramount importance in giving this training. We well know that in the old days a hospital was the lengthened shadow of one person, the so-called "superintendent". This is still true to the degree that policy emanates from the administrator, but we also recognize that today the average hospital is too large and too complex to be unified by one personality. Therefore, in the modern hospital all levels down to the very last janitor must be taught to reflect the leadership and attitude of the management. How shall this effect be achieved without a training program for the non-professional group?

Study and experience have shown that launching such an employee-training program involves four decisions:

(1) Who are to be trained?

An address presented at the A.C.S. sectional meeting in Winnipeg, April, 1947.

** American Hospital Association, "Training of Lay Personnel", Bulletin No. 220, 1942, page 5.*

(2) Who is to be responsible for their training?

(3) How shall training be given?

(4) What training shall be given?

Assuming that the answer to the first question, "Who are to be trained?" is "our non-professional employees", we can proceed to discuss the second, "Who is to be responsible for the training?"

Educational Director

Hospital practices in this regard differ, but all recognize that there is a need for a specialized direction. Many large industries have an educational director who is a staff aid to the personnel director charged with this responsibility. In large hospitals the personnel director is the logical person to direct the training program. In other hospitals, without a personnel director, the administrator or an assistant carries this responsibility. Whoever the leader may be, he must have necessary authority to produce results, and he should understand the principles of teaching. Furthermore, the keystone of the whole program is the wholehearted support of the administration. Some have found it helpful to have an advisory *Council on Training* composed of the administrator and interested department heads. This council meets at regular intervals with the training director to formulate policies and relate these to the broader policies of the hospital as a whole.

With or without the help of such a council, the person responsible for the training program has several approaches open to him in setting up the program. First is consultation with departmental executives and supervisors. Then acquaintance with job analysis and classification techniques, with standards of performance and service ratings for the employees in question is essential. Likewise, he will do well to familiarize himself with any earlier training programs which may have been undertaken at the institution. Survey and a subsequent analysis of the opinions of the professional staff, the trustees, and the patients will be found helpful. Lastly, a survey of opinion among those to be trained may yield many valuable suggestions as to how the program may be carried out and what it should contain.

Methods of Training

Considerations resulting from the above avenues of approach will prepare the way for the decision as to how the training is to be given. Two general methods are in use, usually in combination: group training through courses, lectures and conferences; and individual training, through on-the-job instruction and demonstration. The first method suggests itself for giving instruction in hospital ethics, policies, traditions, and the attitudes which should be common to the entire personnel or to a departmental group. The second is indispensable for teaching skills and is suited to the demands of indidivual jobs. The new elevator operator, for example, can well be given the fundamentals of hospital ethics in a class with many other employees. Fundamentals of elevator procedure and courtesy, however, are better imparted in a small conference of elevator operators; and the use of the controls of the car will be taught effectively only on an elevator.

All lecture courses and group conferences should be given on hospital time. The experience of organizations engaged in employee training has shown that meetings held once a week at regularly scheduled times are the most effective. An hour seems to be the optimum length of the period. Meetings held more often become burdensome and those held more infrequently do not ensure sustained interest.

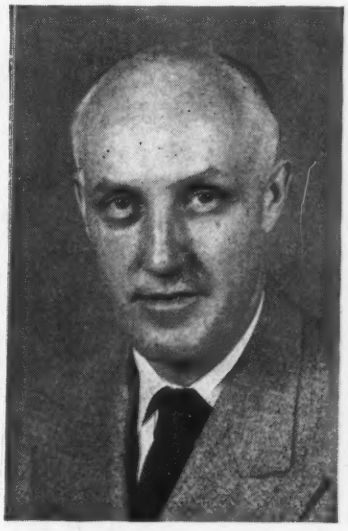
Enrolling the employees in the courses may be compulsory or voluntary. The latter plan results in a better attitude, but compulsion may be necessary to ensure the enrolment of those who are most in need of training. Notices in house organs and on bulletin boards, recommendations of superiors, promises of increased tenure and payroll privileges have all been used as inducements. Whatever the method of enrolment, personnel should understand that regular attendance is expected.

Providing class room conditions acceptable to an adult group will do much to sustain interest. Physical equipment should be such as to facilitate the learning situation, and an informal attitude should prevail. Leadership, rather than domination, should characterize the attitude of the teacher. Utilization of the many techniques perfected by the adult education movement will prove helpful in popularizing the courses.

Complementing this basic course for all non-professional employees are departmental courses for the more homogeneous group. Such courses are taught by the department heads rather than by the director of training. They are, however, a recognized part of the total training program and under the supervision of the director of training. These intradepartmental courses will need

(Concluded on page 86)

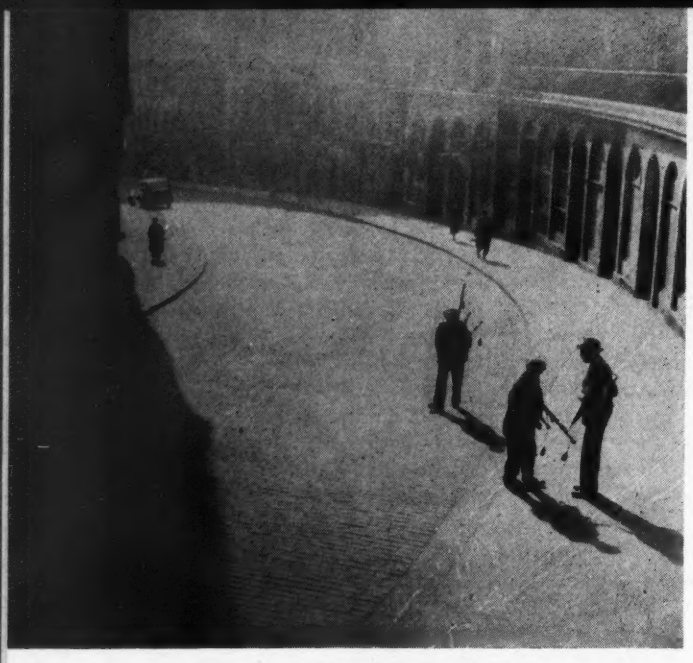
New Appointment at Royal Alexandra



Dr. D. R. Eastman, at present in charge of medical services of the Department of Veterans Affairs for the Edmonton area, has been appointed assistant superintendent of the Royal Alexandra Hospital, Edmonton. He will take over his new position in September. Prior to the War, Dr. Eastman was attached to the Department of Health in Ontario, working chiefly in the field of psychiatry. He then served with the Air Force where he had considerable administrative experience and for the past year has been with the D.V.A.

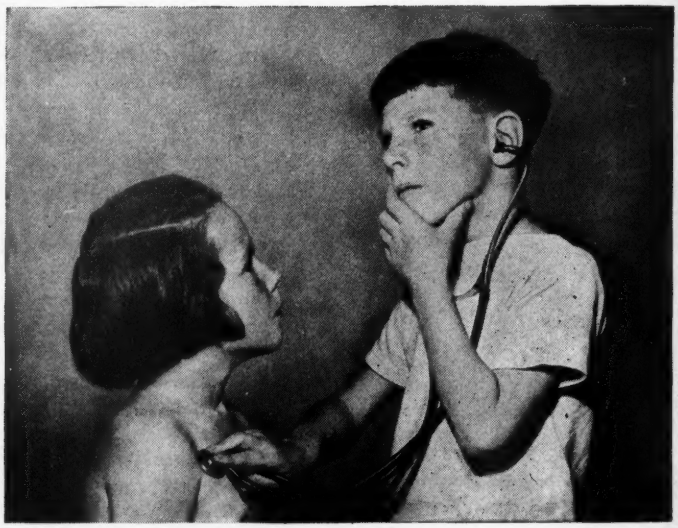
Dr. Eastman succeeds Dr. L. O. Bradley who is leaving the Royal Alexandra Hospital to become associate professor of hospital administration at the University of Toronto.

At the 1947 Canadian Medical Fine Art and Camera Salon



1st Prize—Photography—"Calling the Tune",
Dr. L. M. Hampson, Ottawa.

Prize Winners in the Photographic Section



1st Award of Merit—"Puzzled",
Dr. J. S. Cull, Victoria.

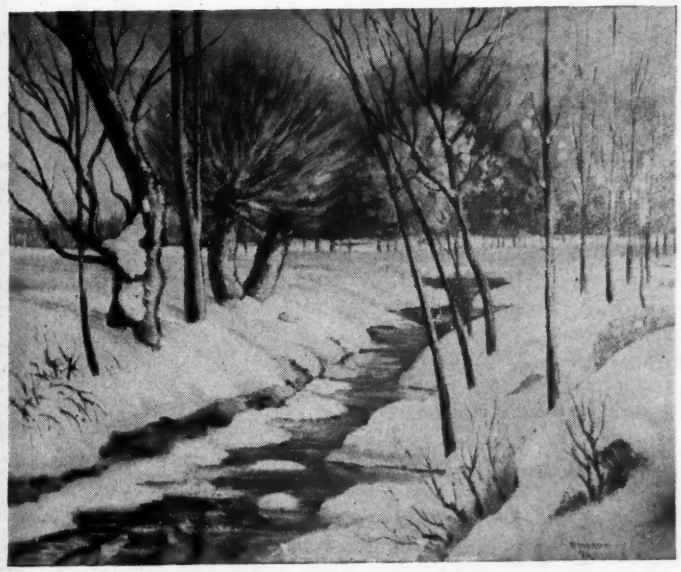
2nd Award of Merit—"Up to Summer Pastures",
Dr. H. F. P. Grafton, Kamloops.

This exhibit at the C.M.A. convention in Winnipeg attracted much attention. There were 187 pieces on display and the quality of the exhibition was of a high order. Competition was keen for the bronze placques of Sir Frederick Banting which were awarded, as first prizes, by Frank M. Horner, Limited, sponsors of the Salon. Prize winners in the Color Photography section, sent in by Dr. J. E. C. Morton of Brandon, Dr. E. A. Petrie of Saint John and Dr. A. B. Ritchie of Guelph, are not reproduced here.

Prize Winners in the Fine Art Section

Right: First Prize—"A Day in Port", Dr. Harvey Agnew, Toronto.

Below: 1st Award of Merit—"Near Ste. Rose, Quebec", Dr. G. E. Tremble, Montreal.



(Unfortunately the main charm of paintings, the handling of colour, cannot be reproduced in black and white).

Below: 2nd Award of Merit—"Pansies", Dr. Albert Jutras, Montreal.

1st Prize—Novice—"Girl with Auburn Hair", Dr. Anna D. Gelber, Toronto.

1st Award of Merit—Novice—"Valley Homestead", Dr. D. C. Hart, Regina.

Obiter Dicta

Doctors Protest Restrictions

THE medical profession in Manitoba has protested strongly against a recent provision of the University of Manitoba, whereby in the now-being-augmented classes in medicine, preference will be given to those who agree to spend at least the first three years of practice in Manitoba. This provision was made to implement an edict passed by the government last winter, authorizing an increase of medical students and giving preference to veterans, Manitoba residents and students who would sign this agreement. The university then agreed to increase the number of first-year students from seventy to ninety. Resolutions of protest against the three years of practice clause have been passed by the Manitoba College of Physicians and Surgeons, the Manitoba Medical Association and the Medical Faculty of the University. Conferences have been held and there is some reason to believe that this provision may not be pressed, although the government action is still "on the books".

This edict is in keeping with a growing tendency today to regulate the lives of our citizens. If it is not being done by governments it is being done by unions and by municipal regulations. In this instance one can understand the thought behind the regulation. Manitoba is launching upon a comprehensive plan designed to improve rural health and more doctors are needed. Although medical college fees seem stiff enough to the student, the major portion of the cost of his education is still borne by the state. Therefore, the state feels that, in compensation for this financial assistance in getting an education, the recent graduate should practise for a few years in Manitoba. There is logic here and much justification.

One cannot overlook, however, the effect this will have on the medical school. Medical students, when they enter, have little idea into what specialty or to what location they will eventuate. Post-graduate work, almost a "must" today, leads them to far centres and to new opportunities. No wideawake student is going to tie himself blindly to a course of action which he may regret bitterly in years to come. Yet the rush to enter medical school is such that an applicant may ruin his chances of acceptance if he does not agree to this stipulation. Moreover, he will realize that medicine is not like many other occupations. One cannot set up practice for three years, then pull out and go on with planned post-graduate work without, in many cases at least, considerable loss. The natural result may well be that the more far-seeing young people will seek admission to other schools. The situation is somewhat parallel to that of the nursing field in Canada. With our acute shortage of nurses there was much criticism of the Federal Government in raising the bars at the border to permit nurses to go to the United States. The Government's viewpoint, however, was that they could not restrict the emigration of one class and not others without creating group discrimination and that, in the long run, such restriction would discourage girls from entering a profession with these limitations.

Why Blame the Hospitals?

MUCH publicity has been given to the investigation of the death and obvious murder of a nurse at Cochrane, Ontario. It is another sad tale of "a few beers" and it is particularly unfortunate that this situation involved a couple of nurses. One feature of the inquest which seems quite uncalled for was the castigation given by A. V. Waters, assistant crown attorney, to the Lady Minto Hospital, where the nurse had been employed. He criticized the hospital for allowing nurses to enter or leave the residence when they felt like doing so. He is alleged to have stated that there was "amazing indifference on the part of the hospital staff and I do not know what the Minister of Health is going to say when he gets a report".

There seems to be both inconsistency and a surprising lack of knowledge on the part of this attorney. He was apoplectic with indignation over evidence which cast doubts on the morals of the murdered girl and practically told the two men that they were lying. Yet he would blacken the reputation of the hospital without hesitation. He displayed a lack of knowledge of modern conditions when he implied that a hospital has a moral duty to keep its graduate staff under close restraint when off duty. Some restrictions are set up for pupil nurses, yes; partly to guard their health and partly to instill the discipline and standards which are part of the development of a nurse. But the hos-

pital to-day does not feel that it can exert very much more control over the private lives of its graduate staff than does a textile factory of a broker's office over the actions of its employees. Most graduate nurses now live out and the hospital intervenes or considers discharge only when a girl's actions interfere with her efficiency on duty, or are a menace to other employees or to the reputation of the institution. The old days when even the superintendent could not leave the hospital without the consent of the chairman are gone and the shortage of nursing staff would be still greater if graduate nurses, old enough to look after themselves, were put under boarding school restraints. The disease of "absenteeism" has permeated employee groups everywhere, and it would be too much to expect that the nursing profession, despite its high standards, would be entirely free of this attitude. For that reason absence to-day does not elicit immediate investigation like it did some years ago. Whether conditions were too lax in this hospital, we do not know; apparently this nurse had already been reprimanded by her superior. We note that the Minister will investigate. Certainly this incident has not added lustre either to the hospital concerned or the nursing profession. Yet the cross-examiner acknowledged the high standards of the hospital when he stressed that, had the girl made the assertion alleged, "it would certainly have called for her dismissal from the hospital".

Saskatchewan Bill of Rights

IN keeping with a widespread realization that racial discrimination no longer has a place in the social economy of a rapidly contracting world, the Satskatchewan legislature at its last session passed a Bill of Rights. This gives every person in the province irrespective of "race, creed, religion, colour or ethnic or national origin" the right to obtain and retain employment; the right to engage in business; the right to own and occupy property; the right of access to public places; the right to membership in professional and trade organizations; and the right to education and enrolment in schools and universities.

This legislation (and a comparable statute has been passed in at least one other large province) is of interest to hospitals as well as to property owners, hotel managers, and the groups primarily concerned. There has been very little discrimination in the hospital field, but, in an organization like a hospital, and particularly in its school of nursing where young people must live together for several years, there is a natural desire that the happiest social relationships should exist. Fortunately, in those hospitals where the races and the religions seem most intermingled, the spirit of tolerance and understanding is most marked. The problem is of much less consequence at the executive, administrative, or the professional levels where prejudice is of minor moment.

The question has been raised: Would this measure prevent a professional body from refusing membership to an individual not of the prevailing race or colour, not because of race or colour but because of undesirability from a professional or ethical viewpoint? The Attorney-General, who introduced the bill, has stated that in his opinion the measure "does not go that far unless the refusal is based on grounds of race, creed, religion, colour or ethnic or national origin". Applications may be refused on other grounds provided the standard is the same for all races and religions. Presumably strictly private groups can set up whatever qualifications they like; that should always be the prerogative of the individual or the private group. This type of legislation is not easy to interpret; discrimination may be suspected but cannot be proven; on many occasions discrimination may be alleged when other factors entirely determined the action taken. It is a step in the right direction, however, for it is largely by greater understanding between the races and religions of the world that future wars will be averted.

Are Standards of Comfort Getting out of Hand?

THE steadily rising level both of construction and of operational cost has again focused attention upon the standards of comfort provided in our hospitals. In our efforts to provide the best possible care have we gone too far? Has this factor contributed unduly to the increased cost?

In construction and equipment could some of our rooms be a little smaller? Must every bed be a gatch bed? Must we have so many toilets — and that somewhat costly flower repository, the bath tub? It would be very easy to say that we must surround the patient with every comfort conducive to recovery and to support that viewpoint with logical arguments to show that each item is either necessary or desirable for the patient, or reduces maintenance costs. But we must draw the line somwhere.

So too with daily operation. Are we justified in giving every private patient a personal telephone, as so many hospitals do? Physicians admit that at least a third and possibly more of the special diets ordered are really not necessary (and in some hospitals 60 to 70 per cent of the patients are on special diet). Do we need to change the linen as often as we do? They would not get as many changes at home. Other features could be mentioned.

No hospital wishes to fall behind the others in making patients comfortable. With the public always ready to criticize, a hospital in this age of competition does not dare to do so. But the fact remains that every added comfort, not to mention the many refinements in treatment, adds just that much to the cost of providing hospital care. In the last year costs have just about reached the limit for most people. It is time to give serious thought to what could be eliminated or reduced without jeopardizing the patients' chances for recovery.

Food and Its Service

Sponsored by the Canadian Dietetic Association

How Clean Are Your Dishes?

JEAN HALL, B.H.Sc.,
Canadian Dietetic Association

THE daily task of cleaning some million dishes throughout the restaurant and hospital fields is almost overwhelming and one which cannot be sidestepped. Increasing knowledge of hygiene and sanitation has emphasized the fact that unsanitary dishes may be responsible for the spread of communicable diseases. Recognition of this fact has led to rather widespread legislation in restaurant and hotel sanitation. Local health authorities are becoming increasingly concerned about the operation of dishwashing since public health ordinances designed to better conditions are being adopted more and more frequently.

Mechanical dishwashing requires adequate space, a good supply of hot water and steam, a detergent, manpower, supervision, and a suitable type of dishwasher.

Adequate space means as much as can be made available—plenty of space on the soiled dish end and on the clean dish end with room for helpers to work without crossing each other's tracks too frequently. The exact kitchen layout will vary with each establishment, but careful thought at the time of installation will be repaid by more efficient future operation.

A kitchen well lighted for pleasant working conditions, as well as inspection of dishes, well ventilated for quick drying and the comfort of workers, and with acoustically treated walls and ceilings, is ideal. A good supply of hot water and steam is imperative for clean and sanitary dishes. A temperature of 200 degrees F. is required for bacteria reduction and quick drying. Rinse efficiency is in direct proportion to the force and temperature of the water, and effective rinsing is obtained in from 10 to 20 seconds at 180-200 degrees F. and 30-50 lbs. pressure.

Detergents play two important parts in the washing process. They soften the water and act as cleansing agents to remove soil from dishes. Compounds may vary greatly and care should be taken in choosing the washing compound which will turn out sparkling china, and help prevent scale being deposited on the interior of the machine. The problem of keeping the proper amount of compound in solution is not easily solved and one which is often overlooked. In the average machine, rinse water sprays into the wash tank, diluting the solution, so that after a few racks of dishes have gone through there is not enough compound left to scrub the dishes clean.

Electric dispensers can be purchased and attached to the machine; in this way the strength of the solution can be measured and the compound lost through dilution can be replaced. However, it is not always practical or possible to attach such a dispenser.

Supervision of Employees

Trained employees are essential to keep equipment functioning properly and to maintain a clean, orderly and sanitary dish room. Wash arms and sprays and rinse sprays must be cleaned at least once a day, and preferably oftener. Rinses and overflows must be checked, scrap trays emptied, curtains or doors scrubbed, and the inside of the machine cleaned and flushed out with pressure hose and hot water. Employees should be trained to clean racks and floors regularly and dispose of broken china and garbage promptly.

Proper supervision of dishwashing starts with the dietitian. Unless the dietitian is willing to devote some thought to organizing and supervising the dishwashing it is hardly likely that anyone else will worry too much about the cleanliness of the dishes. When a dishwashing supervisor is employed it is wise to make certain that adequate and proper instructions are given in the care and use of the dishwashing machine. Training should be given, also, in the good housekeeping details of the department.

Types of Machines

At the present time dish machines are not easily procurable but the types which may be chosen for future delivery are the single tank machine, the single tank conveyor type, and the multiple tank conveyor type. All are operated on more or less the same principle—that is, the dishes after being scraped are packed loosely in racks, plates on end and cups and bowls placed upsidedown in open type racks. They are then placed in the machine and cleansed by the wash and rinse processes.

In the single tank machine the wash water is pumped from the wash tank and sprayed over the surface of the dishes; the water passes through the wash tank strainers or screens which retain the major portion of the soil removed from the dishes, reenters the wash tank and is circulated again. Small particles of soil and bacteria pass through the strainers and are deposited on the surface of the dishes, and while all visible soil is removed the dishes are still contaminated by the bacterial content of the wash water. The final cleansing is accomplished by the action of the rinse water, which is sprayed over the dishes and enters the wash tank diluting the detergent solution and overflowing into the trap, flushing

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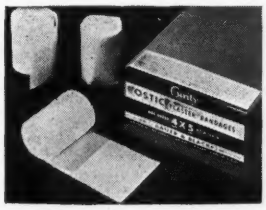
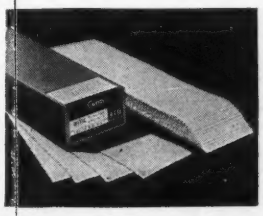
**Monro, J. K.: The History of Plaster-of-Paris in the Treatment of Fractures. British J. Surgery, 23: (90) 257-266 (October), 1935.*





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away particles of soil and grease. Reduction of organisms in wash water is effected during each rinse process. Sterilization is effected by the internal temperature of the dish itself and can be accomplished only if dishes are rinsed at 190 degrees F. for one minute.

Multiple tank machines are equipped with separate tanks from which the wash and rinse waters are continually circulated over the surfaces of the dishes. The action is identical with that of the single tank machines. The dishes reach the rinse tank contaminated with minute soil particles, which together with soil and bacteria from the conveyor belt, are flushed into rinse by the action of the rinse sprays and re-circulated. Unless there is a final rinse of clear water supplied directly from the hot water line the dishes will remain contaminated with bacteria. An effective detergent assists in the rapid removal of soil from dish surfaces and aids in the removing of bacteria.

The installation of a pre-flush tank is helpful in eliminating soil from entering the wash tank of the machine. A few of the newer models include this tank which operates at a water temperature of 115-120 degrees F. Dishes enter the tank and are flushed, soil is removed and drained away and drainage does not enter the wash tank. The suggestion of a four-inch air space between tanks would seem to be an excellent arrangement in avoiding drainage from one tank into another, and facilitating the temperature control of each tank. A few modern principles are being incorporated into newer machines but there might be a great deal more thought and planning to give a more efficient and productive piece of equipment.

The Wartime Dishwashing Machine

During the war an entirely new type of machine was built and operated in one of the larger war plants. Particular advantages of this machine include efficient operation by a small staff and the elimination of heavy lifting. The machine and conveyor are oblong with a multiple tank machine on one side of the section. The first tank or pre-flush is maintained at a temperature of 130-140 degrees F., or less. There is an air space between the pre-flush and wash tank, which operates at a temperature of 160 degrees F. and another air space before the dishes finally enter the rinse tank at 200 degrees F. The dishes, after passing through the machine, move around the conveyor and are air-dried.

Dish racks are unnecessary in this machine. Small wire containers approximately eighteen inches by four move around on the conveyor belt and through the machine. These containers are removable for cleaning purposes and are constructed with metal upright pegs protected by rubber banding.

After dishes reach the soiled dish table by conveyor from the dining room, they are removed by the workers and scraped. They are then placed individually between the pegs in an upright position in the containers as the conveyor reaches the soiled dish table. Silver is placed in small wire mesh baskets which also fit in the conveyor racks; trays are packed between the pegs. The conveyor moves through the machine and its speed is so timed that dishes remain in each tank the required time to remove soil and effect sterilization. By the time the conveyor has moved to the clean dish station the dishes are air-dried. They are then removed, packed on trucks and bussed to the dining room. Silver and glassware are as effectively handled as dishes and a great advantage of this machine is that all types of tableware can be washed at the same time. Heavy lifting is eliminated and the operation requires but a few workers.

Good Machines Needed

While kitchen equipment experts stress the desirability of incorporating ideal working conditions in our dishwashing sections — adequate lighting, good acoustics, easily cleaned floors, plenty of hot water and steam—it is essential that dishwashing machines will operate on a basis resulting in high production, with minimum effort. These requirements should offer opportunities to manufacturers: machines designed to eliminate heavy lifting; soften water before entering the machine; eliminate drainage of water from one tank to another; dry dishes without stain in a drying cabinet; keep temperature of tanks constant; arrange controls and valves in positions to avoid reaching and bending, have pre-flush tank separated from wash tank and wash tank separated from rinse tank to avoid seepage of water back and forth; and arrange a clear water spray of high temperature for dishes leaving the machine. Some of these features have been incorporated into a few machines but they are not standard equipment.

Arthur W. Smith Goes to Summit, New Jersey

Arthur W. Smith, assistant superintendent of the Royal Victoria Hospital, Montreal, has resigned to accept the superintendency of Overlook Hospital, Summit, New Jersey. This is a general hospital with an extensive building program in project, expected to require six to eight years before reaching completion. It is the only hospital in the area serving twenty-five municipalities.

Mr. Smith takes with him to his new duties on September 1st a wealth of experience gained in the field of hospital administration. Educated in Toronto, he spent seventeen years in various posts with the Department of Public Health in that city. As secretary-treasurer of the Toronto Hospital Council in 1939-40, Mr. Smith organized the first hospital collection and credit bureau sponsored by the Council.

Mr. Smith went to the Royal Victoria Hospital in September 1940, and since that time has worked with Dr. George F. Stephens in the reorganization and future planning of that one thousand-bed teaching hospital.

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Dermalon sutures, the products of years of intensive research and clinical observation, are improved monofilament strands characterized by absolute impermeability, a desired degree of elasticity and smoothness of surface. *Surgilon* sutures are braided from nylon filament and specially processed to eliminate knot slippage and assure non-capillarity, stability and compatibility. Both are obtainable through responsible dealers everywhere. Davis & Geck, Inc., Brooklyn, N. Y.

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Economic Aspects of Hospital Administration

PART III

PERCY WARD,
Chief Inspector of Hospitals and Institutions (B.C.)

ACCOUNTING is a language. It is a language of figures. Its purpose is to transfer thought, to paint figure pictures, and to convey to the inquirer the true story of the economic journey of an enterprise. Every person interested in hospital accounting as a specialty should learn the fundamentals of book-keeping first — and there are many sources through which this can be studied. If you wish to know something of the economic progress of your hospital you must first have a clear grasp of the meaning of the words "revenue" or "income" and "expenditure".

You increase by revenues; you decrease by expenditures. The difference is gain or loss. Receipts and disbursements are activities quite extraneous to profit or loss as far as accounting records are concerned. However, receipts and disbursements must be watched because neglected receipts lead to loss in revenue, and indiscreet disbursements may run you short of cash when you need it. But do not let these items blind you to the truth regarding your economic progress or your profit or loss.

Departmental Costs Accounting

Departmental costs are important if they are accurate. They are worse than useless unless they are accurate — they are misleading. Complete departmental cost accounting involves considerable clerical work by a trained person experienced in distributing general costs accurately. The average small hospital usually has neither the trained personnel to carry out this special work, nor can it afford to engage such personnel. Departmental cost accounting is essential to the efficiency of a hospital large enough to be divided into more or less self-contained special departments, but even here it is doubtful if these costing records should be used exclusively when fixing charges for service rendered.

The information of primary importance for every hospital to know is the total cost of service to all patients. Admittedly, it is not possible to record everything of economic significance that happens in a hospital, yet it is possible to record all tangible changes of economic significance, at the same time noting other factors which tend to improve efficiency and economic stability.

Hospitals are established for a purpose. There are rules, and there are ethics accepted from experience as advancing the interests of the institution. There are few activities as complex as hospital work. The accountant who installs a hospital accounting system should know the fine points of the game if he is to be permitted to decide the lines upon which economic records are to be kept; what shall be recorded and how the recorded data shall be classified and compared. Hospital accounting involves something much more comprehensive than the counting of money and the recording of money transactions. If a hospital accountant is to be able to submit accurate reports, he must know what is going on; why it is going on; and what economic significance should be attached to what is going on.

No enterprise is sociologically sound unless it is also economically sound. The controlling factor in every enterprise is economic. Finance is only one part of economics. There is such a thing as "spoiling the ship for a ha'penny worth o' tar". This applies not only to commercial enterprises but also to activities where social good is a dominant factor. The economic factor is always present, and it always has the final word.

* "Voluntary hospitals are becoming more conscious of the need of uniform accounting by which they may, through comparison, judge the efficiency of their activities."

Accrual Accounting

Accrual accounting for hospitals is gaining favor and, in the opinion of the writer, will be universally adopted as soon as all hospitals, including small ones, understand its nature and value. Briefly, accrual accounting consists of recording every change in potential wealth at the time the change occurs. It is wise to keep in mind an appreciation of one of the elementary principles of economics, namely, that money, as such, is not wealth, but is merely a medium of exchange. Under normal circumstances receipts and disbursements of money neither add to nor subtract from the wealth of a hospital, except of course, when money is received or paid without compensation, as in an outright gift. When a patient pays his bill, he is merely cancelling his debt, which should have been recorded as revenue of the hospital at the time the service was given. When supplies are paid for, money is exchanged for a liability, and no change in wealth occurs. Wealth is reduced when the supplies are consumed.

Hospital Accounting is a Specialty

Success in installing a suitable and efficient system of accounting in a hospital is dependent, apart from a knowledge of the fundamentals of book-keeping, upon an understanding of the procedures necessary to achieve the objectives of a hospital, and of the psychology and ethics of hospital work. The accountant must understand and appreciate the viewpoints of attending physicians, nurses, technicians and patients, and they

From lectures given at the Manitoba Administration Course, Winnipeg, October, 1946.

* *"Taking Hospitals Into Account" written by the author for "Hospitals", December, 1941.*

Here's proof... *that glass can tame the sun!*

Modern glass research has learned how to make the sun *behave!* Here at last is glass for factory windows that reduces employee eyestrain and fatigue, cuts down product spoilage—by 'filtering out' as much as 48% of solar heat and glare!

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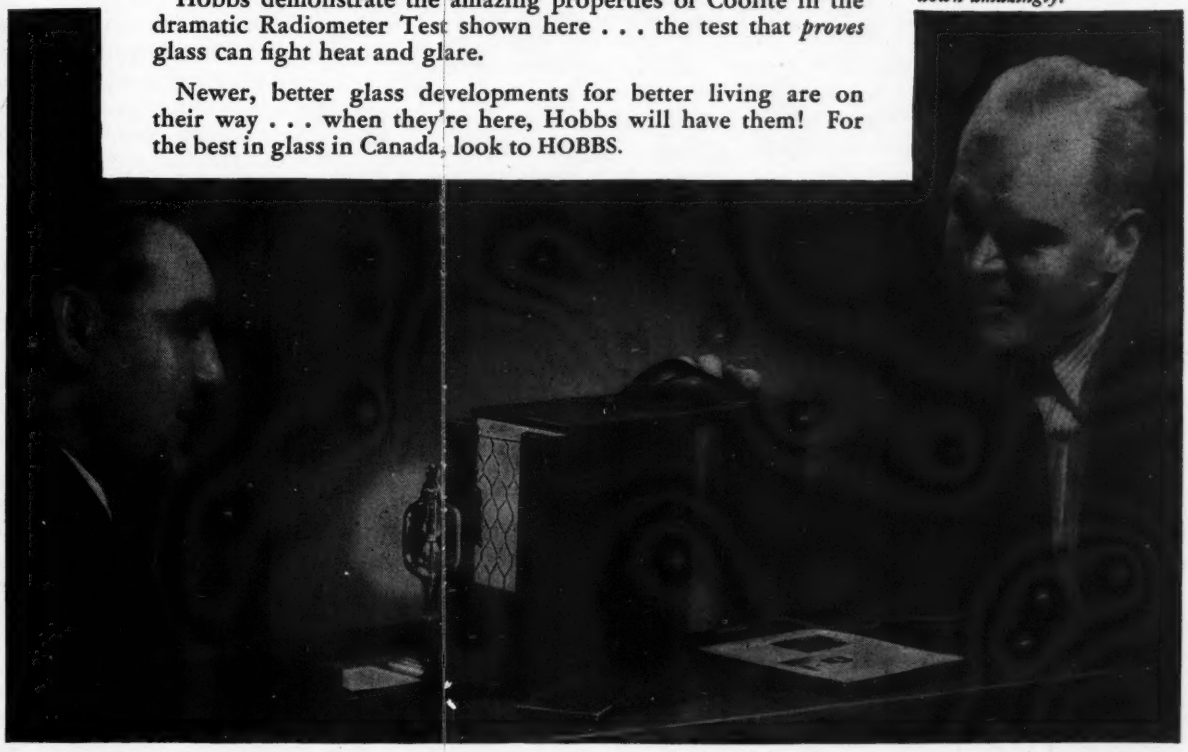

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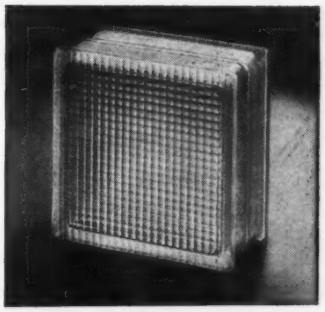

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must understand his. In deciding the framework of an accounting system for any hospital, there are two pitfalls that should be avoided: first, multiplication of detail records having very minor significance which tend to cloud the main issues; second, failure to demonstrate the important economic facts clearly.

Every hospital, whether large or small, should know the value of what it possesses and owns, and what it owes to others in respect of what it possesses and owns. This information should be set out clearly upon a balance sheet, so that the hospital may have a "still-life" picture of its wealth at any time. All other accounting records should be related to and connected with the balance sheet. Hospitals are centres of intense activity and in order to keep pace, a continuous diary should be kept in the form of two primary sets of records. One set should record, chronologically, all activities that add to the hospital's wealth, and the other, all activities that subtract from that wealth. When the lesser total of the two records is subtracted from the greater, the difference will disclose the extent to which there has been a gain or loss during the period covered by the two records. In accrual accounting everything that has been earned and to which the hospital is legally entitled is considered, primarily, to be an addition to wealth — revenue. In the case of service to a patient, the total amount of the bill at the regular schedule of rates is considered to be revenue. Everything that is consumed is an expenditure. The payments made in respect of what is consumed are not expenditures. The accounts payable in respect of supplies and goods purchased are, however, used as a medium through which expenditures can be ascertained.

Knowledge of Expenditure

There are several methods by which expenditures can be ascertained: (a) By the central store system whereby supplies from the store are charged as expenditures at the time they are issued for use; (b) In hospitals too small to operate a central store, all purchases can be charged direct to "stock", and charged out again as expenditures by estimating the fluctuations in the stock by means of a perpetual inventory; (c) A third method for the small hospital consists of analyzing the accounts payable each month, estimating how long the supplies will last, and entering the estimates in a synoptic book. Whichever method is used, the hospital can be assured that some method of ascertaining expenditures is vital to those who desire to see where they are going.

Mixed Statements

It is true that a mixed statement of a type in common use, wherein receipts are shown upon one side and the amounts representing Accounts Payable are shown on the other, may be used as intermediary records by means of which at the end of the year the economic status of the hospital may be learned. But this semi-cash method involves a reconciliation of all items in relation to stock on hand at the beginning and end of the year, of accruals, and of overdue and prepaid items. This method leaves an administrator in complete economic darkness during the year; yet, assuming all reconciliations to be properly made, will generate some light at the end of the year. The captain of a ship sailing towards a given destination would probably wander far from his proper course if he were able to check with his compass once a year only.

Classifying Revenue

The primary object of a revenue and expenditure statement is to show whether the hospital is gaining or losing. Classification of the items can be arranged so as to provide valuable information, but subdivisions should not be allowed to cloud the primary object. In classifying the revenue items of a hospital, the information of greatest importance is the earning power in respect of services to patients at a consistent schedule of rates. If a hospital, at normal occupancy, learns that its potential earning power from services to patients equals its expenditures, it learns at the same time that in the aggregate its schedule of rates is equal to the cost. If they are unequal, it learns the extent of the inequality. Individual rates may justifiably be far removed from the cost and yet be eminently fair and equitable. No good purpose can be achieved by trying to ascertain the exact cost of giving service to any particular patient, because no two patients ever cost identical amounts, even though both may be suffering from the same illness. The factors to be considered in deciding upon the rates for individual services include: (1) the cost, (2) the desirability of uniform basic rates within the same geographic area, (3) the occupancy of the hospital during the period under review, and (4) the relationship between supply and demand, whether in connection with special equipment and services or with the relative number of public wards, and private and semi-private rooms available. The aim should be to see that in the aggregate the total potential earning power at the adopted schedule of rates is adequate to produce enough revenue to equal the cost of operation at normal occupancy.

Clarifying Revenue

As every hospital suffers loss through non-payment of hospital bills, a useful purpose is achieved by subtracting that portion which is uncollectable from the gross earnings from service to patients at regular rates. The seriousness of this loss in many hospitals suggests the desirability of analyzing it in order to learn its causes. Classifications of such losses may include: (1) loss from business discounts; (2) loss from services given as a courtesy to employees and others connected with the hospital; (3) loss from services to persons unable to pay and not likely to be able to pay in the future; and (4) loss resulting from nonpayment of accounts by persons able to pay, but from whom the hospital has been unable to collect. The first of these classifications will help the hospital when making contracts. The second will enable the hospital to check abuse of its facilities and discover what benefits given to employees are actually part of the salary cost. The third should be of value when approaching governments and public charity organizations, and the fourth will enable the hospital to check the efficiency of its collection methods.

When a hospital learns the extent to which its gross earnings from services to patients will not materialize, it is next concerned with finding out from what sources it must endeavor to make up the deficiency.

(Continued on page 76)

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Arrangements Complete for Edmonton Institute

THE Committee in charge of the Institute on Hospital Administration to be held in Edmonton this fall has completed arrangements and an excellent program has been planned. A condensation of the program as it will be printed follows:

Registration: All communications regarding registration should be sent to the registrar, Mr. G. Hollingshead, University of Alberta Hospital, Edmonton. Advance registration will facilitate the work of the committee.

Registration Fee: There will be a registration fee of ten dollars.

Living Accommodation: Early reservation requests are encouraged by the committee as it is considered improbable that reservations will be available after September 15th.

Field Trips: Field trips will be made to Edmonton hospitals. Operation of the following departments and others will be demonstrated: central surgical supply rooms, central food service, cafeterias and dining rooms, kitchens, records, business office set-up, physiotherapy, nurseries and operating room services.

The Program

Monday, October 20th

Registration. — Official Greetings.
Purpose of the Institute—Malcolm T. MacEachern, M.D., Chicago.
Instructions to Members—Angus C. McGugan, M.D., Edmonton.
Hospital Ethics—Harvey Agnew, M.D., Toronto.

Afternoon Session

Some Elementary Facts about the Law—Nelles V. Buchanan, K.C., Edmonton.
Question Period—Statutory privileges and legal liabilities.
General Organization—Basic Elements—Kenneth Williamson, Chicago.
Medical Staff Organization in University Hospitals—Harry Coppinger, M.D., Winnipeg.
Medical Staff Organization in Large General Hospitals—Rev. Fr. Bertrand, Montreal.
Medical Staff Organization in Hospitals of under One Hundred Beds—Morley Young, M.D., Lamont.
Round Table Conference—Malcolm T. MacEachern, M.D., Chicago.

Tuesday, October 21st

Organization of Schools of Nursing in Hospitals without University Affiliation—Miss Elinor M. Palliser, Reg. N., Vancouver.
Organization of Schools of Nursing in Hospitals—Miss Helen Penhale, Reg. N., Edmonton.
The Training of Nursing Aides—Miss Jean Frances Ferguson, Reg. N., Calgary.
Personnel Problems and their Solution—A. J. Swanson, President, Canadian Hospital Council, Toronto.
Unionization—Boon or Bogey?—Leonard P. Goudy, Saskatoon.
Professional Organizations as Bargaining Agents—Miss E. Kathleen Connor, Reg. N., Calgary.
Pension Plans for Employees—Donald M. Cox, F.C.I., Winnipeg.

Afternoon Session—Hospital Tours and Demonstrations

Evening Session

"Stump the Experts" — Presiding, Harvey Agnew, M.D.; collaborators—The Faculty.

Wednesday, October 22nd

Nursing Services in Urban Hospitals—Mrs. J. E. Porteous, Reg. N., Saskatoon.
Nursing Services in Rural Hospitals—Miss Marjorie Gordon, Reg. N., Lacombe.
Dietary Services—Miss Grace A. Torrie, B.Sc., Edmonton.
Laboratory Services—Owen C. Trainor, M.D., Winnipeg.
Relationship between Urban and Rural Hospitals—M. R. Bow, M.D., Edmonton.
The Hospital and the Public—William Ryan, Regina.

Afternoon Session

Control of Surgery and Operative Obstetrics in Smaller Hospitals—A. Somerville, M.D., Edmonton.
The Patient—His Friends and Relatives—Angus C. McGugan, M.D., Edmonton.
The Maintenance of Clinical Records—Malcolm T. MacEachern, M.D., Chicago.
Hospital Administrators as Humanitarians—Percy Ward, Vancouver.
A Day in the Life of a Nurse-Administrator—Miss E. Eleanor Bray, Reg. N., Edmonton.
Hospital and Nursing Services on the Frontiers—Miss Jean Clark, Reg. N., Edmonton.
Round Table Conference—Kenneth Williamson, Chicago; collaborators—The Faculty.
Institute Dinner—Presiding, Leonard Wilson, Edmonton; speakers:—A. J. Swanson, "Let's Tell the World"; Malcolm T. MacEachern, M.D., "Hospitals of Yesterday, Today and Tomorrow".

Thursday, October 23rd

Business Principles Applied to Administration—Geo. Masters, Vancouver.
Collection Department and Collection Methods—Percy Ward, Vancouver.
Hospital Purchasing—L. R. Adshead, Edmonton.
Functions of the Admitting Office—Murray Ross, Edmonton.
Role of Physical Medicine in Hospitals—M. C. Adamson, M.D., Edmonton.
Safeguarding Laundry—J. Ross Vant, M.D., Edmonton.
Operation of the Laundry—M. D. Schneider, Edmonton.

Afternoon Session—Field Trips

Trustees' Day—Friday, October 24th

Engineering Problems—Vernon Pearson, P.Eng., M.E.I.C., Edmonton.
Hospital Governing Boards—Kenneth Williamson, Chicago.
Hospital Prepayment Plans—A. F. Anderson, M.D., Edmonton.
Highlights of the Institute—Harvey Agnew, M.D., Toronto.
Round Table Conference—Malcolm T. MacEachern, M.D.; collaborators, The Faculty.

Afternoon Session

Symposium: Provision of Hospital Services with Special Reference to Rural Areas:—
In Manitoba—Speaker to be named.
In Saskatchewan—Gordon E. Wride, M.D., Regina.
In Alberta—Hon. W. W. Cross, M.D., Edmonton.
In British Columbia—Percy Ward, Vancouver.
Future of the Voluntary Hospital—A. E. Archer, M.D., Economic Advisor, C.M.A., Lamont.
Question Period—A. E. Archer, M.D., and the four speakers.

* * * *

Associated Hospitals of Alberta

Thursday Evening, October 23rd

Registration. — President's Address. — Reports.

Friday Evening, October 24th

Municipal Hospital in Retrospect and Prospect—E. E. Maxwell, Edmonton.
Resolutions re Municipal Hospitals.

Saturday Morning, October 25th

Government Returns—John McGilp, Statistician, Edmonton.
Resolutions, Legislation and Election of Officers.

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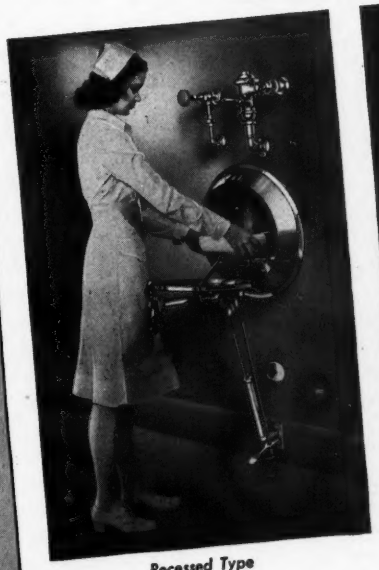

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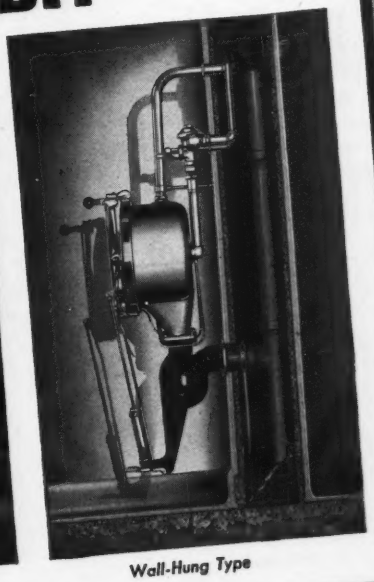

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Can Increasing Costs *be met without* Lowering Standards?

OWEN C. TRAINOR, M.D.,
Misericordia Hospital, Winnipeg, Man.

TO THE uninitiated, with a penchant for oversimplification, the answer is obvious—raise the charges. The hospital administrator, however, will not be impressed with this solution. He is only too conscious of the inflexible provisions of "the law of diminishing returns". The charges for hospital services are already adjusted to the extreme limit of the paying capacity of the clientele—or beyond. Further increases can result only in driving patients to the lower cost wards, or in creating new classes of hospital indigents, with a concomitant drastic decline in revenue. Quite clearly the cure would be worse than the disease. This easy and tempting solution must be rejected.

Two Alternatives

Can we find other ways out of this impasse? Two possible points of attack present themselves:

(1) A search for all possible economies in controllable operating expenditure.

(2) New sources of revenue or increase in existing sources, apart from increased charges to patients.

With regard to the first, one may say that already our hospitals are operating at the lowest possible cost, and that additional economies, except at the expense of standards, are quite impossible. I wonder if we are not too complacent in this regard. There is such a thing as being too close to a problem to see its elements in proper perspective. It is the fashion to laugh at the efficiency expert, but it may be that an independent survey of our institutions, in their economic aspects, might reveal possibilities for economy which we have entirely overlooked. Such a survey would demand the services of a person with a wide and complete knowledge of hospital operation, but at the same time, one whose primary mission should be to suggest economies in operation without sacrifice in efficiency.

It is possible to recall instances of uneconomic practices in hospitals that have come under our own personal observation. For example, many hospitals are purchasing prepared parenteral solutions from commercial manufacturers. Many others, with the use of modern manufacturing equipment and skilled personnel, are able to produce in their own premises solutions entirely comparable in quality and safety at a fraction of the cost. When one considers the large sums expended for these solutions the possible saving will not be inconsiderable. Those of you who are fortunate enough to have a skilled machinist on your engineering staff do not have to be reminded of the extraordinary economies he can achieve in the construction of many types of hospital equipment. A good hospital pharmacist, with manufacturing skill, may save his institution thousands of dollars yearly. Here it may be necessary to obtain the sympathetic co-operation of the medical staff, and a modicum of education may be needed to offset the siren song of the detail man.

These are but a few economies that come to mind; I have no doubt but that a searching analysis of our hospital procedures would reveal many more. Some of these economies may seem small and comparatively insignificant, but in the aggregate they may loom large. Moreover, in these days of mounting deficits there is a moral obligation on every hospital administrator to satisfy himself, the public, and the government, that available revenue is being utilized to the best possible advantage before appealing for additional financial support.

The time has arrived for government to assume the full cost of caring for the medically indigent.

Additional Revenue Needed

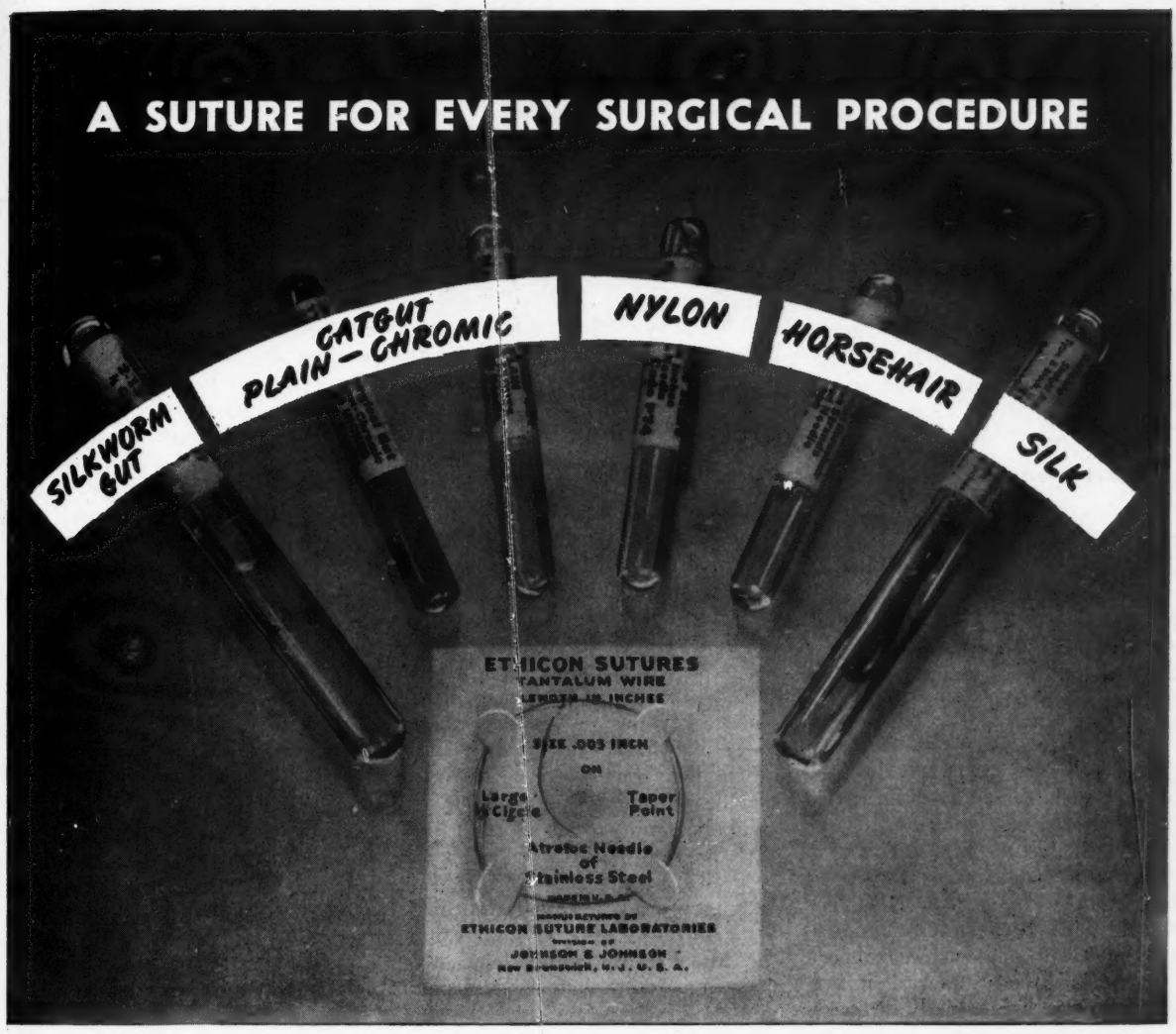
While intelligent economy may assist in solving the financial difficulties of our hospitals it will fall far short of a complete answer. Additional operating revenue is an urgent and immediate necessity. The possibility of obtaining additional revenue by increased charges to patients has been examined and found wanting. There remain but two other sources to explore: (1) income from private endowment and (2) government assistance.

In Canada, at least, the first mentioned source can be dismissed as impracticable. Hospitals with large endowments in this country are so few as to be numbered on the fingers of one hand, and the existing taxation structure precludes the probability of any tangible increase. This brings us to the one remaining source of additional revenue — government aid.

Government has contributed substantially to the development of the voluntary hospital in Canada. Indeed, it is probably no exaggeration to say that without this assistance hospitals, as we know them today, would not have existed. This assistance has been given largely on the assumption that the care of the indigent sick was a responsibility of the state, and that this responsibility could be discharged most economically by subsidization of the voluntary hospital. The present difficulty arises from the fact that this responsibility of the state is being discharged only partially—because subsidization does not cover the full cost of caring for the indigent patient. In the past, this lack of balance between cost and subsidy, although it impeded hospital progress, did not

(Concluded on page 84)

An address at the 1947 Winnipeg Hospitalization Conference of the American College of Surgeons.



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With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Dear Mr. Editor:

When there is so much constructive work to be done in all departments of the national life, the question of priorities is extremely difficult. At the present time there is a wave of enthusiasm in connection with the care of the old people. That, however, is a subject with which I dealt in your April issue. Moreover, it is clear that the long term policy must keep the welfare of the rising generation well to the fore.

It is just forty years ago since the School Medical Service was started by the Board of Education. It was recognized that the first step was to establish a *systematic inspection of the health of the school child.* The standard has been steadily progressive so that, to quote a recent report, "whereas formerly medical inspection was successful chiefly in detecting early illness, latterly the aim has been to provide a complete audit of the child's health".

Treatment did not become compulsory until 1918 and has never been interpreted as applying to more than a small number of ailments mainly affecting the eyes and teeth, tonsils and adenoids. It is now recognized that the orientation towards a "positive" outlook in health matters demands a service which will give attention to the *whole development* of boys and girls in sickness and in health, in school and at home. It is clear, therefore, that the activities of the Ministry (as it is now) of Education have a most important contribution to make in the new national health service. The indirect effect, to which reference has been made, is that a generation has been educated to appreciate the methods of preserving health and the value of counteracting any deterioration from the normal.

Admittedly, any definite program to carry into effect an adequate health service for the rising generation is not quite so simple as it appears on the face of it. In the first place there is the position of the family doctor, for it is far more important for the children to be dealt with in their *family relationship* than as pupils of the same school. In this connection the association with the health centres may develop as the key to the right solution. If the doctor, who knows the mother in her own home, is the same as the one who sees her in the maternity clinic and in due course knows the child in the infant welfare centre, then it is obviously desirable that he should not lose sight of the child upon going to school, or at least that the record of the child should be available at the centre. The Ministry recognizes this in the statement that "for the sake of continuity within the school health service itself it is most important that the maternity and child welfare and education authorities in all areas should employ the same medical staff as well as the same nursing staff".

The Minister of Education in setting forth his plans for the guidance of the authorities envisages a three-party conference of teacher, parent and doctor, at regular intervals. The children are to be studied at work and at play, but questionings are arising in the minds of some as to whether the home and the family have their rightful place in this picture. To this triumvirate is to be added the school nurse for the effective practical side of the work, especially while there is a shortage of doctors available for the service. For this purpose it is desired that there shall be close collaboration between the health visitor and the school nurse. Here again there is a movement which is full of promise on the part of district nurses to obtain an additional qualification for *health visiting.* In the midst of conflicting claims it seems to be clear to the onlooker that this approaches more nearly to the solution of the problem. If the district nurse attends the mother in her confinement in her own home and if necessary follows the babe to the infant welfare centre, then there is a valuable contribution to the maintenance of the health of the family as a unit.

A Positive School Health Service Plan

It is significant that the demand for an improvement in the present conditions comes *from the people themselves.* The Workers Educational Association, which is a representative body, has put forth a claim that "what is wanted is a school health service positive in conception and thoroughly co-ordinated. . . . There is failure to teach children to reach a higher standard of health by natural means, sleep, fresh air, balanced diet".

In two directions the education authorities have an opportunity to extend their activities under the powers granted by the Education Act of 1944. The adolescent, who has been singularly overlooked in the past, can now be reached by the raising of the school age to fifteen and later to sixteen, and by extending the School Health Service to the County Colleges. The other direction in which the education authorities will be able to make a special contribution is for the benefit of the children, handicapped physically or mentally. The Society of Medical Officers of Health have summed up the situation in the comment: "The requirements of the Education Act with regard to handicapped children have tremendous possibilities."

1872 1947

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In the far off days of '72 when Canada was young, when the destiny of a new Dominion was being shaped by those who made Confederation possible, men of vision and enterprise were fashioning the foundations of Canadian industry.

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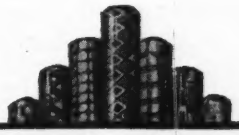

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Post-Operative Haemorrhage *from Tonsillectomy*

ROBERT BLACK, M.D.,
Winnipeg, Man.

THE main causes of post-operative haemorrhage from tonsillectomy are:

(a) Blood dyscrasias. Here a careful history will usually elicit some information warning one of the presence of these conditions.

(b) Poor or careless surgery, resulting in injury to the muscle tissue. Frequently this is due to being in too much of a hurry.

(c) Incomplete removal of the tonsil.

(d) Neglecting to check completely bleeding in the operating room.

A complete history with blood pressure, bleeding and clotting time should be made but is not absolutely essential.

Haemorrhage usually occurs within the first eight to twelve hours after operation. At this time relatives are often present and it is a very alarming and distressing complication for them, as well as for the surgeon and the nursing staff.

Signs of Haemorrhage

The prompt recognition of the signs and symptoms of bleeding is very important. These are: restlessness, pallor, sweating, thready rapid pulse, and finally vomiting of blood.

Statistically, bleeding from the adenoid area is more dangerous than bleeding from the tonsil, partly because much blood may be swallowed without external evidence, especially in children, and also because the bleeding point cannot be seen. The nurse doing post-operative care, particularly in the case of children, should be thoroughly familiar with all these signs and symptoms of bleeding and should be prepared to start prompt action for its control.

The importance of bleeding after tonsillectomy is shown by the amount of literature on the subject. Loeb reports that of 444 deaths following ear, nose and throat surgery, meningitis accounted for 168; haemorrhage came next with 76, of which 62 were cases of tonsillectomy with or without adenoidectomy. This indicates that tonsillectomy should not be regarded as a minor procedure. However, three large clinics report a total of 77,732 cases with no deaths, proving the importance of good surgery and good post-operative care.

In my experience I know of only two cases, both in children, of fatal post-operative haemorrhage, due entirely to lack of early recognition of the seriousness of the condition and failure to institute prompt and immediate relief. Even though the number of fatalities is not large in comparison with the number of operations done, there should be no excuse for a patient dying from this type of haemorrhage while in hospital.

The Hospital's Responsibility

Hospitals and their staffs are in existence for the care of patients. When a patient enters hospital for any surgical procedure he is entitled to the best care available.

Broadly, there are three types of general hospitals: (a) the large metropolitan hospital with full intern and nursing staffs; (b) the intermediate hospital with no intern staff but an efficient nursing service; and (c) the small community hospital, with few beds and limited nursing care.

A haemorrhage tray, complete with the necessary equipment, should always be available for immediate use in each of these types of hospital. Morphine should be given routinely, in adult cases, to combat shock and allay fear.

In the Large General Hospital

1. Efficient anaesthetic and nursing care in the operating room is essential, so that the best type of surgery can be performed. Complete control of bleeding should be attended to before the patient leaves the operating room.

2. On return to the ward, the patient (especially in the case of a child) should be supervised by a nurse who is fully qualified and familiar with the signs and symptoms of haemorrhage. Interns should always be available; they should know the proper methods of control and treatment, including the use of blood plasmas if indicated.

In the Intermediate Hospital

Here it is doubly important that all precautions for the complete control of bleeding should be taken in the operating room, and that, on return to the ward, the patient should be under observation by a nurse who is fully conversant with all the signs and symptoms of bleeding and who is qualified to carry out the proper procedures until the arrival of the attending surgeon.

In the Small Hospital

The small hospital is often in a village or town, with only one or two practitioners. In this case, when tonsillectomies are performed, the hospital should always have available a qualified nurse who is not only capable of post-operative care but who, in the absence of the surgeon, has the ability and training to undertake the necessary procedures on her own initiative.

Conclusion

(a) In view of the danger of fatality from haemorrhage, tonsillectomy or adenoidectomy should not be considered as minor procedures.

(b) From the hospital standpoint, every step in the operative procedure should be carefully performed and if the complication of haemorrhage does occur, prompt and efficient teamwork on the part of both the surgical and nursing staffs is essential.

(c) Until fully recovered from the anaesthetic, no post-operative patient should be left in the hands of a nurse or other individual who is not fully aware of the early signs and symptoms of haemorrhage.

"Cases of venereal disease in Canada increased from 40,900 in 1944 to 45,000 last year. Penicillin seems to offer the key to both gonorrhoea and syphilis as far as control of communicability of V.D. is concerned." — *Dr. D. B. Layton, Canadian Public Health Convention.*

An address at the hospital section of the American College of Surgeons meeting, Winnipeg, April, 1947.

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Here and There

Medical Practice in Ancient Greece

The following is excerpted from "Social Life in Greece" by J. P. Mahaffy of Trinity College, Dublin, which was published by MacMillans of London in 1874. Mr. Mahaffy was not only a scholar and writer but a seasoned traveller of the last century.

WE find that there were two schools — the old quackery of charms and incantations, and the rational observations and treatment of disease by empirical remedies. In Homer the former seems prominent, and so it was even in the days of Pindar and Aeschylus, though the latter . . . mentions real surgical and medical treatment. He also makes an allusion very characteristic of the Greek temper, and one that indicates the coming development of medicine: 'To those that are sick it is sweet to know clearly beforehand what they have yet to suffer.' Such an allusion points to no charms of wonder-working, but to the prognosis of the physician who has learned by experience what to expect from known symptoms.

This rational school had in truth been developed earlier than the age of Aeschylus, and strange to say, not in relation to disease, but in relation to high physical training for athletic purposes. Plato, indeed, ascribes the origin of treatment by regimen to Herodicus of Selymbria, 'who being a trainer, and himself of a sickly constitution, by a happy combination of training and doctoring, found out a way of torturing, first himself and then the rest of the world." So then Greek medicine rather started from hygiene than from pathology. The trainer found that amulets and spells were of no use against better physical conditions. We find the most celebrated early school of medicine at Croton, which was also the home of the greatest athletes.

The tyrants, and in imitation of them the free cities, began to bid for men of this school, and give them high yearly salaries for residing among them. The case of Democedes is well known. He ran away from a cruel father at Croton, and came to Aegina, where he set up in private practice; and, 'though destitute of the needful appliances, outstripped the best physicians of the place in one year'. Aegina, being at that time the most frequented seaport and emporium in Greece proper, was able to employ him as a state physician the following year, for a talent (£244); but the Athenian tyrants next year bid £406 for him, and the fourth year he was engaged, for two talents (£487) by Polycrates, the most powerful Greek prince then living. Such a salary seems enormous at this epoch among the Greeks.

However, we see here the habit of having state-physicians, to which Aristophanes, Plato and Xenophon make many allusions in after days. There was a technical term for such practitioners at Athens, and the scholiasts on Aristophanes say they did not take private fees . . . which would account for the high state-salary. Plato implies plainly enough that the profession was taken up by men of culture and education . . . and also that they were publicly elected by the assembly, and that they distinctly based their practice on experience; it seems certain from Xenophon that they sent in applications for the post, in which they doubtless stated their claims, and perhaps even got testimonials as to their private practice. That their salary was large is not only implied by Democedes' case, but by Aristophanes who states that owing to the poverty of the city there was no doctor (I suppose state-doctor), and that accordingly the craft had greatly declined. It is, on the contrary, noticed among the perfections of Spartan military arrangements, that a safe place was allotted to certain indispensable attendants on the army, and among these are mentioned *military surgeons.*

Though Xenophon speaks of their visits to patients morning and evening, I fancy that this applies to an inferior class of private practitioners, and that the state-physicians were consulted at their official residence. They had a number of assistants, some of them slaves, who treated simple cases, and more especially the diseases of slaves, going in and ordering the patients to take their remedies, whereas with free men the practice was to persuade the patient, by full explanation of the treatment, that it would succeed. Plato is very interesting on this point. In the case of the free man, 'he will not prescribe till he has persuaded him'. A still more remarkable case, if true, is that mentioned in the *Gorgias,* where Plato says that the physicians used to take with them Gorgias, who was the most persuasive rhetorician of the day, in order that he might persuade the patients to adopt their prescription.

These things are very curious and show to what a pitch the Greeks had brought the habit of inquiry and argument, regardless in this case, as it seems, of the very bad effect such discussions must have had on the nerves of many patients. But I must add, in fairness to them, that this habit of persuading the patient cannot have been universal. Plato himself speaks of enforced treatment, and Aristotle, a generation later, specially notes that the physician's duty was not to compel or to persuade, but simply to prescribe. . . . We have even a hint of such a habit (persuasion) being ridiculed, 'For by this you may be sure,' says the Athenian speaker, 'that if one of these empirical physicians, who practise medicine without science, were to come upon the gentleman physician talking to his gentle patient, and using the language almost of philosophy — beginning at the beginning of the disease, and discoursing about the whole nature of the body — he would burst into a hearty laugh, he would say what most of those who are called doctors always have on their tongue: — "Foolish fellow," he would say, "you are not healing the sick man, but you are educating him, and he does not want to be made a doctor, but to get well." "It appears, then, that though fashioned and thought philosophical, this persuasive treatment was even in Plato's day beginning to be duly appreciated.

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Credit to be Given for Laboratory—X-Ray Short Courses

LAST year the province of Saskatchewan inaugurated dual short courses for laboratory and x-ray technicians. This step was taken in order to meet the anticipated demand for technicians on the part of small hospitals under the new health legislation. The courses consist of three months' diagnostic laboratory work and three months' instruction in x-ray technique, the training being given in approved centres and in accordance with a carefully-compiled curriculum. It is planned that when technicians so trained are placed in small hospital laboratories, their work will be supervised through periodical visits by a senior laboratory director.

There was no thought of turning out fully qualified technicians by this method. It was a matter of meeting the immediate need, and both the Canadian Society of Laboratory Technologists and the Canadian Society of Radiological Technicians indicated willingness to give credit for the amount of training received in this way, should these technicians wish to qualify for membership in either society at a later date. Accordingly a joint committee was appointed to study a system of credits for the dual short course which could be applied toward the requirements for registration with the C.S.L.T. or C.S.R.T. Members of the committee were Miss Ileen Kemp and Mr. George Darling of the C.S.L.T., Mr. P. E. Hunt, C.S.R.T., assisted by Dr. A. E. Perry, radiologist, and Dr. W. A. Riddell, pathologist.

After careful consideration Mr. Hunt and Miss Kemp presented reports and recommendations to their respective societies. As a result definite policies have been formulated.

C.S.L.T.

The Canadian Society of Laboratory Technologists has set forth regulations for the guidance of students who have taken the dual course of training in Saskatchewan and wish to become fully qualified technologists.

1. Students must have senior matriculation or the equivalent standing, including chemistry and one other subject.

2. The three months' laboratory training in urinalysis and haematology will be accepted by the C.S.L.T. toward the twelve months' period required of any candidate for examination. The succeeding nine months of training in the various laboratory departments must be taken in a training school approved for the purpose by the Canadian Medical Association Committee on Approval of Schools for Technicians.

3. Students must commence their additional training not later than two years after the initial three months' training period.

4. Students completing this initial training will be eligible for student enrolment with the C.S.L.T. for one year. The student enrolment fee of $1.00 will include one year's subscription to the *Canadian Journal of Medical Technology*. The following year, unless the student is again enrolled for further training in laboratory technique in a training school, he or she may receive the journal for $2.00, the regular subscription rate to non-members of the Society. Student application forms may be obtained from Dr. W. A. Riddell of the Provincial Laboratories, Regina, Saskatchewan.

C.S.R.T.

The recommendations of the committee to the board of directors of the C.S.R.T. are still under consideration but it is expected that these will be adopted at the annual meeting of the Society next month. These are, in brief, as follows:

On commencing the initial X-ray training period, students may obtain student membership in the member-society of the province after payment of the required provisional fee. Upon completion of the initial short course the student shall receive a written indication to this effect from both the radiologist and the pathologist in charge.

Following not less than 27 months' service in the field, under supervision, the student may undertake additional studies for the purpose of obtaining registration by examination. Further study must be under the direction of a qualified radiologist and shall occupy the student's full time for a period of not less than three months.

Should it be impossible for the student to obtain full-time instruction for three months, he may accept employment in a hospital under the supervision of a qualified radiologist and thus obtain the necessary instruction. In this case the time period must not be less than nine months. The student must then receive written acknowledgement from the radiologist in charge that the required additional study, according to either of the above methods, has been satisfactorily completed.

The student may then, upon payment of the required fees, write the examinations set from time to time by the Board of Examiners of the C.S.R.T. In making application for examination students must present declarations from radiologists concerning both periods of training. It will be noted that the total training period of radiographic experience required before examination is 33 months or 39 months, depending upon whether the student has had full-time or part-time instruction during the second period.

If in view of the increasing demand for health services of all kinds, other provincial governments should adopt similar plans of combined training, the groundwork is now laid for arrangements by which technicians who have had this partial training may proceed to qualify for membership in either of the national bodies.

A.C.S. Hospital Conference to be Held in New York

As part of its annual Clinical Congress at the Waldorf-Astoria, New York, the American College of Surgeons will hold a four-day Hospital Standardization Conference from September 8 to 11.

Twelve sessions are scheduled, opening with a general assembly on Monday morning, September 8th.

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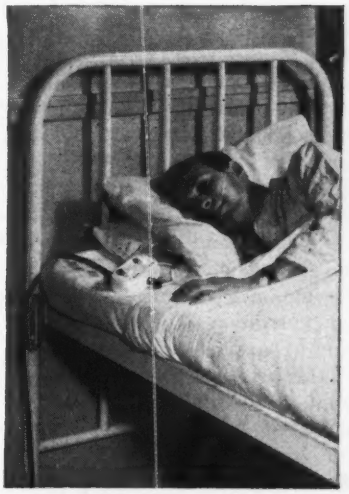

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◄ Blue Cross News ►

Pre-paid Medical Plans Not to Absorb Blue Cross

Press reports in late June indicated that plans are being developed to form a nation-wide prepayment medical care plan which would eventually take over the Blue Cross plans. This was a misinterpretation of the interview given by Dr. G. F. Strong of Vancouver, chairman of the Committee on Economics of the Canadian Medical Association.

Prior to the C.M.A. meeting in Winnipeg a conference was held of representatives of the various plans selling voluntary, non-profit, prepaid medical care. This was called by the C.M.A. Committee on Economics. Many matters of mutual interest were discussed and the possibility of forming a Dominion-wide plan to handle national enrolment was given initial exploration. There was no discussion of hospital care coverage, we are informed, the agenda dealing entirely with medical care. The importance of individual, as well as group enrolment was stressed, if the public are to be adequately covered. It was stressed, too, that these plans should have adequate non-medical representation on their boards. These plans are primarily for the benefit of the public and a false impression is apt to be created in the public mind respecting the real purpose of these plans if there is any insistence upon medical preponderance on the boards. The strictly medical aspects of administration, however, should be under a committee of the doctors.

* * *

Blue Cross Discussions

During the past few months directors and board members of the five Blue Cross plans in Canada also have been discussing the possibilities of national unification. No definite action has been taken as yet. However, it would appear that a unified national plan to supersede the present regional plans is not at all likely. It is more likely, if any action is taken, that some national office may be set up, supported by the individual plans and authorized to deal with national enrolment where that is essential on behalf of the individual Blue Cross plans. Experience has shown that many large firms with branches in various parts of the country are desirous of having membership available to all of their employees, no matter where located.

* * *

Welland County Votes To Participate in Plan

The Welland County Council recently voted to pay a portion of the cost if county employees wish to join the Blue Cross hospitalization plan. A committee has been appointed by Warden George F. Broadley to make a survey of county employees for this purpose.

It was pointed out in county council session that the introduction of the plan would make jobs in the county a little more attractive and, if generally adopted, would result in reducing hospital deficits and assist in cutting down hospital grants.

Welland County is the third Blue Cross group in which the municipality is sharing the cost with the employees. Teck township was the first, and was followed by Windsor, the first city to pass a bylaw governing participation in Blue Cross.

* * *

Maritime Blue Cross Marks Fourth Anniversary

The Maritime Hospital Service Association has recently completed four years of Blue Cross participation. During the four years of its operation the plan's office has enlarged from a single room to the present extensive offices covering three floors of a building. Some three thousand claims are handled monthly by the hospital claims branch. The recent approval by legislation of handling wider protection, covering surgical and medical benefits to be added to hospital protection, is a forward step which will place this plan in the vanguard of voluntary service plans working on the development of full health protection for all.

* * *

Blue Cross Abroad

Two claims, one in Hawaii and the other in England, have been met by the Maritime Blue Cross. Both claims were for maternity care and the babies have been enrolled in the plan.

* * *

A Male Maternity Case

Resourcefulness of the Delaware Blue Cross Plan in facing up to unusual situations is shown in the fact that it has just paid the bill of a man who was hospitalized in a maternity ward. The man, Rudolph J. Van Daalen, recently returned from Brazil, where he was hospitalized in the British Colony Hospital at Rio de Janiero, told Group Hospital Service the story. He was first put in a ward and then transferred to a semi-private room; later he was moved again, this time to a private room. Only when friends came to call did he realize that the room was in the maternity section of the hospital, the only part of the overcrowded institution where a room was available.

—Blue Cross Bulletin.

Montreal Research Institute Receives $15,000 Donation

Since its founding in 1945, the Institute of Experimental Medicine and Surgery of the University of Montreal has received financial assistance through a grant of $15,000 per annum from the pharmaceutical house of Frank W. Horner. The grant has recently been renewed for another two years. With this support the Institute, which is growing rapidly, will be able to increase further its extensive research on hypertension. An important part of its work is the training of graduate scientists for careers in research; at present there are students from Mexico, Brazil, Cuba, France and Greece, as well as Canadians.

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Correspondence

First Prize Winner Replies

To the Editor:

I was greatly surprised, as well as pleased, to receive your letter saying that my article on "Chinese Medicine" had been awarded a prize of $100.00 by *The Canadian Hospital.* I had not known that any such prize was being awarded and, therefore, it came as a complete surprise. However, I am very grateful for the award.

Our university, like the other twelve Christian universities in China, is having serious difficulties with finances. We are to quite an extent dependent upon foreign funds, the largest source of which is the U.S.A. Subscriptions there to projects in China have decreased to a great extent, and so the prospect for the new year is not bright. The head of every department is being called to the president's office to personally justify every expenditure, for at least a thirty per cent cut seems to be inevitable.

With our university this policy of retrenchment seems to be extra difficult, for we are in a part of the country that is politically stable — or at least seems to be so. As a result, many students from the war areas are seeking an education here in the west. Inflation has not hit us as hard in Szechwan as nearer the coast, so that the cost of living is only about one-third of what it is in Shanghai and Nanking. Lower costs also bring many students to this part of the country, since they cannot afford to live in the more expensive regions. These temporary reasons as well as our increased popularity during the war give us very great opportunities, and yet we are being ordered to reduce students, decrease staff, and to cut expenditures generally.

To minimize the cuts we have started a financial campaign to raise money in China. The instability of the currency is a major problem, since when money is subscribed it may be worth three or four times its purchasing value at the end of a few months. The official exchange rate is now 12,000 to 1 for the Chinese and American dollars. But the black market is again flourishing, and the rates there are almost three times the official ones. The price of rice in Chengtu has quadrupled in the past three or four months, although there is no shortage, and the prospects for a crop this year are excellent. So, as always happens in an inflation, the white collar class get pinched, and our Chinese staff are having serious difficulties making ends meet. When I got your letter I sent a cheque for the Canadian $100.00 to our finance campaign committee chairman, and I think he felt greatly encouraged by this gift — really a donation from *The Canadian Hospital.*

Cordially yours,

Leslie G. Kilborn, M.D.

Director, College of Medicine, West China Union University, Chengtu, Szechwan.

* * *

Second Prize Winner Also Writes

To the Editor;

I wish to thank you for the kindly compliments in your letter informing me of the award for the article on Lord Lister, "The Greatest Modern Englishman". This is an honour that I highly appreciate, one that I can never forget, a grand climax to the many esteemed letters I received from the readers when the article was published.

Moreover, there was a large fund of pleasure in preparing the script; in the revivifying of many happy memories of several years; the impressive experiences of a decade of lay services in an English practice where Listerian principles dominated all surgery — major or minor; the daily association and conversations of that period with doctors who had studied under Lister—all these imbued me with an ardent devotion to that ideal which was characteristic of the man and his eternal verities. . . . Motivated by that sentiment I would like to turn the pecuniary part of the award back to the field of activity wherein Lister achieved greatness. I am endorsing your cheque "payable to the Cancer Fund" and have asked Dr. A. K. Haywood to present it to that service in the name of Joseph Lister.

Sincerely yours,

W. Hargreaves,
5829 Willingdon Place,
Vancouver, B.C.

Book Reviews

LAW RELATING TO HOSPITALS AND KINDRED INSTITUTIONS By S. R. Speller, LL.B.; pp. 400, price 22s. 6d.; published by H. K. Lewis & Co., Ltd., London, 1947.

The author of this well written book is one who has had considerable contact with hospital problems. For some years he has been secretary and director of education of the Institute of Hospital Administrators. He is also editor of *The Hospital.* Formerly he was a lecturer on banking and law at the City of London College.

The publication of this work has been delayed for several years, partly owing to wartime difficulties and partly to the desirability of awaiting completion of certain changes that were being made with respect to statutory rules and orders as they related to the Nurses Act of 1943 and to the broader changes brought about by the National Health Service Act. Actually the latter group of statutory rules and orders has not as yet been completed, but it was not thought desirable to delay further the publication of the book as the basic principles of the new health service and the essential changes to be made are now clearly defined and subsequent developments with respect to administrative detail and further orders and regulations can be presented in a later companion volume.

The author deals with hospital constitutions with limited powers and responsibility; with the general powers of hospital authorities; with consents to operations and analogous matters; injuries to patients and others; detention of patients against their will; the handling of persons of

(Concluded on page 82)

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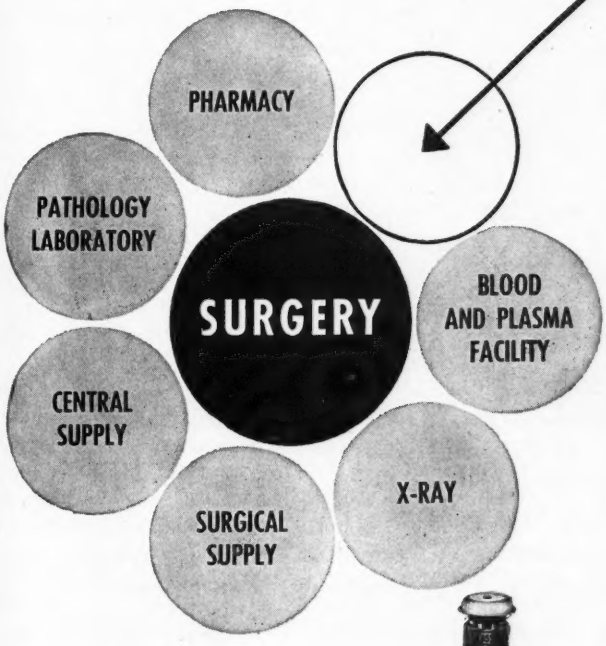

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Provincial Notes

British Columbia

NEW WESTMINSTER. Ratepayers here have approved the second $600,000 bylaw which enables the hospital board to proceed toward the completion of the $1,600,000 hospital addition. The additional funds will provide for the purchase of much-needed modern equipment, accommodation for forty more nurses at the nurses' home, and the erection of a second connecting wing of two storeys to the new six-storey addition.

* * * *

PORT COQUITLAM. Construction will start as soon as plans have been approved by the board, of a 32-bed wing to the Mission Memorial hospital here. The addition is expected to cost around $50,000. A new X-ray machine, costing over $4,000, has been purchased and set up in the old building until it can be installed in the new one.

* * * *

LITTLE MOUNTAIN. Preliminary plans have been drawn for the construction of a $3,000,000 hospital on a ten and one-half acre site on the northeast side of Little Mountain. Work on the project is expected to start sometime this month. Gardiner and Thornton of Vancouver are the architects.

* * * *

TRAIL. The Trail-Tadanac Hospital Society has purchased thirteen acres at a cost of $11,400 as a site for a hospital which the society proposes to build when construction costs return to a more reasonable figure than at the present time.

* * * *

COURTNEY. Construction has commenced on a modern medical clinic here which will have overall dimensions of 70 x 50 feet and will be in the shape of a cross to gain the maximum in natural lighting. The building will contain a large waiting room, four doctors' offices, x-ray room, dark room and laboratory.

VANCOUVER. Plans for a new 815-bed hospital to modernize Vancouver General Hospital at a cost of close to $8,000,000 have been submitted to the provincial government by the B. C. Medical Association, the Vancouver General Hospital, civic officials and members of the staff and directorate of the University of British Columbia.

Alberta

CALGARY. Plans have been approved and work is expected to start shortly on the construction of a 150-bed hospital for crippled children. The project is under the direction of the Alberta Junior Red Cross Society.

* * * *

EDMONTON. The Royal Alexandra Hospital here has received an X-ray machine bought through the donation of $1,500 from the Alberta Tuberculosis Association. The Edmonton and Calgary General Hospitals were each offered $1,500 to buy equipment, which would be used to check all admissions for tuberculosis.

Saskatchewan

PRINCE ALBERT. Completion of additions and alterations now being made at the Victoria Hospital here will permit an average increase of more than twenty per cent in patients receiving care. A new addition of brick and concrete construction will have three floors and will connect the old section of the building with the new wing, which was taken over from the Department of National Defence. Service departments will be located on the first floor and above, on the main floor, administration and admitting offices, doctors' room and a large public waiting room. The maternity ward on the third floor will have twenty additional beds, while an enclosed fireproof stairwell from this floor to the basement will permit swift removal of patients in the event of an emergency. A new power plant has been completed at a cost of $27,000 and provides sufficient power to supply all buildings on the square.

* * * *

MOOSOMIN. Work is expected to start immediately on the new $65,000 addition to the Union Hospital here, which will increase the present bed accommodation by at least fifteen beds. The addition has been made possible through the generosity of the Moosomin General Hospital board, who also donated the nurses' home and the old hospital.

* * * *

REGINA. The contract has been awarded covering a $20,781 enlargement to the power house of the General Hospital here. The addition will house heating equipment for the new hospital wing.

* * * *

WATSON. The Union Hospital here, first of a series of provincial government-planned and sponsored hospitals to be finished, has opened its doors for the admission of patients less than a year after construction started at the end of August last year. The 36-bed hospital, which was officially opened last month by Premier T. C. Douglas, is supplied with the finest, most modern equipment. Over one thousand members of the community attended the official opening of the hospital.

* * * *

WAWOTA. The district's first hospital is to be officially opened soon and will serve this village, the municipalities of Wawken and Walpole and a portion of the Moose Mountain municipality. Wawota has a population of 350 and the members of the area are planning to make their $60,000 hospital debt-free by the time it is opened. Cost of the 15-bed institution has been met mainly through public subscription and the provincial government grants and only $6,000 remain outstanding on the total amount.

Manitoba

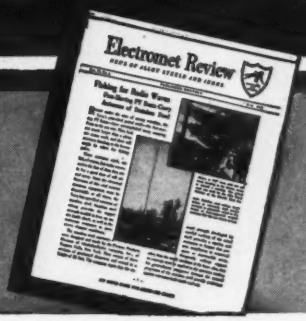
WINNIPEG. Announcement has been made that a new Shriners' Hospital for Crippled Children is to be built at 611 Wellington Crescent at

(Continued on page 80)

Attractive and Long Wearing

Years of service have not lessened the attractive "spick and span" appearance of the stainless steel steam tables and other equipment in this hospital staff kitchen.

Constant use has demonstrated that stainless steel not only appears clean, but is easily kept clean. The smooth, hard surface of stainless steel is resistant to rust and corrosion, and does not easily dent or scratch.



Other interesting uses of stainless steel are described in ELECTROMET REVIEW, published by ELECTRO METALLURGICAL COMPANY OF CANADA, LIMITED, producers of alloys for making steel. If you need this publication, send your name on your business letterhead to ELECTRO METALLURGICAL COMPANY OF CANADA, LIMITED, Box 912, Welland, Ontario.

British Applicants Desire Positions in Canada

A number of letters are being received from administrators and others in Great Britain desiring positions in Canadian hospitals. Many of these applicants are well trained and it is unfortunate that distances are so great. In some instances they could only obtain travel space if they have a definite post to which to go. The following are examples:

Medical Physiotherapist

A well-qualified masseur and electro-therapeutist, aged forty-nine holding three degrees issued by the Chartered Society of Massage and remedial Gymnastics, with over twenty years' experience in physiotherapy, wishes to come to Canada, but cannot arrange passage unless he has assurance of a position and a place to live. It is presumed that he is also a physician, as he writes: "I am a medical man." All equipment, which he used in his practice in the Jersey Channel Islands, was destroyed by the Germans. He has had considerable hospital experience and would like to bring with him to Canada, his wife, their daughter, who is a first-class stenographer, and his mother. His address is W. G. C. Moore, 3 Leigh Mansions, Oakmount Avenue, Southampton, England.

Administrator

An applicant of British nationality, thirty-six years of age, and a bachelor, desires employment as a hospital administrator or as an assistant administrator. He took his hospital training at the Hull Royal Infirmary, a general hospital of 397 beds, and while there sat for the examinations of the Institute of Hospital Administrators, passing the Final examination in 1939.

In 1940 this applicant was named assistant secretary at the Preston Royal Infirmary, another general hospital of 475 beds, where he did much of the purchasing for the institution. He was awarded the Fellowship of the Association in 1941. For the next five years he was in the Army and was stationed for two years in Washington with the British Joint Staff Mission. He is now back at Preston as assistant to the administrator. During September he hopes to visit Canada and the United States and could arrange interviews at that time. His address is Mr. J. L. Bateman, Royal Infirmary, Preston, England, or c/o C.H.C. office.

Mass Survey Record Set by Swift Current

What is believed to be a world's record for cities was achieved by Swift Current in a recent anti-tuberculosis survey, when 96.3 per cent of the population was examined by x-ray, according to Dr. C. F. W. Hames, deputy minister of public health for Saskatchewan.

It was also indicated that people throughout the Swift Current area had responded enthusiastically and, in most municipalities, the attendance for x-ray checkup numbered over 90 per cent of the population. Several villages and hamlets had 100 per cent attendance.

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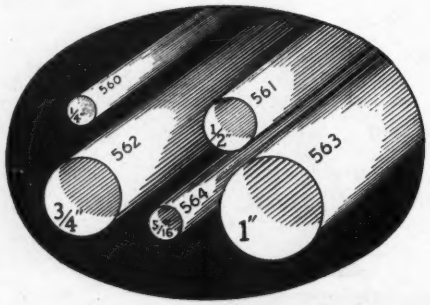
in eighteen and thirty-six inch lengths. Made from the best obtainable grades of natural latex.



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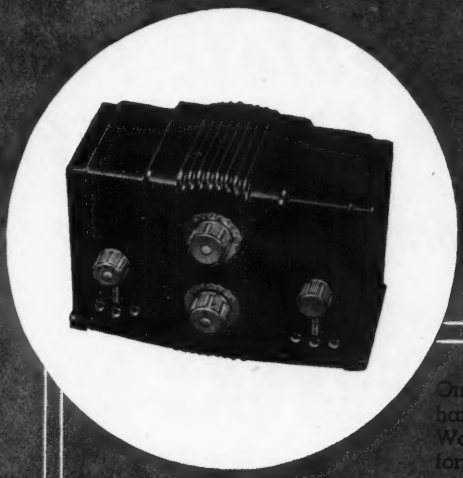

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One is immediately impressed with the handsome, dignified appearance of this Wappler Major Cautery and Light Transformer. Housed in a lustrous molded case with a contrasting color for the controls, this beautifully designed instrument will enhance any doctor's office equipment.

Whenever the use of thermal cautery is indicated, the Wappler Major Cautery is the choice of doctors everywhere. It has ample power for all cauterization procedures and its added exclusive Wappler convenience features account for its wide acceptance by the medical profession. Two ranges of diagnostic light current are available. Separate light controls are provided for both cautery and light regulation that provides a nicety of control which greatly facilitates the work in hand. The Wappler mono-plug connection outmodes all other cauteries. The comfortable pistol-grip handle fits the hand naturally. The pistol-grip handle, exclusive with Wappler, cannot heat, is light in weight, nicely balanced and can be sterilized by boiling. The convenient trigger switch controls the heating of cautery tips. The built-in spotlight is so located that the electrode casts no shadow into the brilliantly lighted operative field.

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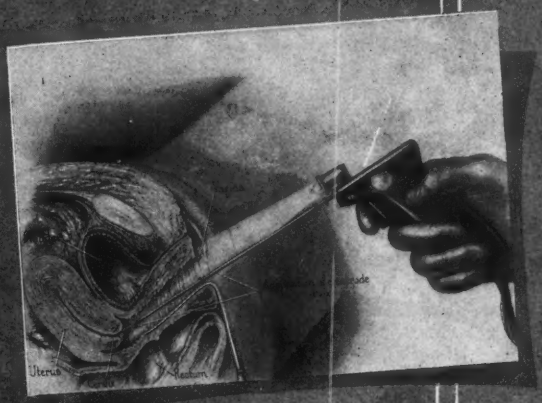
- ☆ *Trigger Switch Control*



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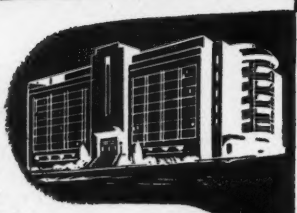

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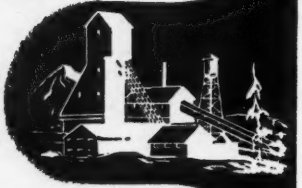

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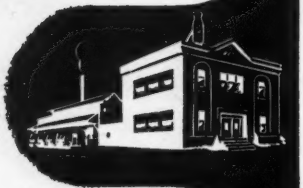

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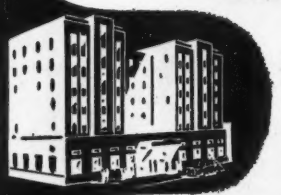

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Economic Aspects

(Continued from page 52)

Nearly all voluntary hospitals give some services to persons unable to pay. Operating revenue from various government authorities, and welfare organizations, and donations from private individuals, may usefully form a separate classification. Further classifications may be necessary to cover miscellaneous operating revenue, and capital income.

Expenditures

Useful general headings for classification of expenditures may include: (1) salaries and wages; (2) supplies; (3) purchased services; (4) depreciation; (5) repairs and minor replacements, in addition to miscellaneous headings covering insurance, rents, taxes, interest, et cetera. Each of these general headings can be subdivided to suit special circumstances.

Receipts and Disbursements

Experience indicates that many hospitals regard records of money received and paid out as being the only book-keeping records necessary. It is the writer's opinion that this is entirely wrong. Cash records alone are almost useless as a guide to a hospital's economic progress. They are often worse than useless — they are misleading. A hospital may have more cash on hand at the end of the year than at the beginning, and yet be suffering a heavy loss on the year's operations. Cash records are important and they must be kept accurately, but no good purpose can be achieved by analyzing these cash records into detailed classifications with the apparent intent of ascertaining revenues and costs.

Classification of cash receipts into: (1) patients' accounts receivable; (2) donations; (3) government grants; and (4) miscellaneous, would appear to be sufficient for all the ordinary purposes of a small hospital. Classifications of disbursements beyond two or three general headings usually have no economic value whatsoever. The important information regarding cash is the total received, the total paid out, and the balance on hand.

Unit Analyses

Every small hospital should keep the more important records that indicate its economic progress as a complete institution. If, without neglecting this most important information, it is possible to keep detailed analyses by departments, such records can be made useful. But to attempt such detail records without a competent cost accountant serves no purpose and it is likely to produce misleading results.

The General Ledger

The general ledger is the index to a hospital's economic position at any given time. In order to be compact and useful, all accounts in the general ledger should be in the nature of control accounts. All subdivisions of control accounts should be kept in subsidiary accounts. A greater number than fifteen to twenty control accounts in a general ledger is likely to create unnecessary work and to be more confusing than helpful. A trial balance should be made each month and if a trial balance cannot be made in half an hour, the probability is that the time has arrived to consolidate a number of the

(Concluded on page 78)

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CLINITEST

For Qualitative Detection of Urine-Sugar

Clinitest is the latest improvement on copper-reduction tests. The reagent tablet is dropped in diluted urine and heat is self-generated. Supplied in bottles of 100 or 250 for hospitals, in laboratory outfits and pocket-size plastic sets for physician and patient.

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CONTUSION OF THENAR MUSCLES

A Treatment by means of Elastoplast

Figure 1.

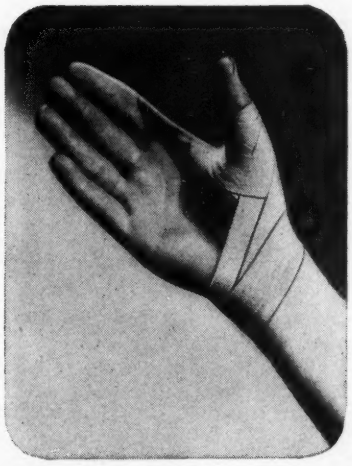

Figure 2.

CASE HISTORY

An iron worker, aged 26, fell against an iron bar which he struck between the thumb and first finger. When examined on the 6th August there was clinical tenderness of the thenar muscles but X-ray showed no fracture or dislocation. A one inch wide Elastoplast Plaster was applied, spica fixation.

A fortnight later, there was slight tenderness and another Elastoplast Plaster was applied. On the 10th September the Elastoplast was removed. There was no tenderness or pain on gripping and the patient was discharged. The details and illustrations are of an actual case.

T. J. Smith & Nephew Ltd., manufacturers of Elastoplast, are privileged to publish this instance, typical of many in which their products have been used with success in the belief that such authentic records will be of general interest.

In the **ELASTOPLAST ELASTIC ADHESIVE PLASTERS** a combination of the particular adhesive spread with the remarkable **STRETCH** and **REGAIN** properties, together provide the correct degree of compression and grip. They mould readily to any part of the body without slipping, rucking, or constriction

In the treatment of sprains and strains, Elastoplast should be firmly bandaged over the joint for some distance above and below. It should be applied as soon after the injury as possible, thus immediately providing firm support and controlling the formation of effusion and haemotama.

Elastoplast Plasters available are 1 in. wide x 1 yd. (1¾/2 yds. when stretched) and 1 in. wide x 3 yds. (5/6 yds. when stretched). Elastoplast, Elastocrepe, Jelonet and Gypsona are products of T. J. Smith & Nephew Ltd., Hull, England.

•

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378 St. Paul Street West,
Montreal, Quebec

(Concluded from page 76)

ledger accounts, or, alternatively, to weed out superfluous ones.

Conclusion

In summing up these discussions you are asked to consider the activities of a hospital as being likened to a watch. A watch may have all its parts complete, but it is of little value unless it continually informs us of the correct time. Unless the works of the watch are appropriately placed in relation to each other; unless the wheels intermesh as one aids another to keep turning; unless the spring is wound at regular intervals; unless the balance wheel functions properly and accurately, the usefulness of the watch is impaired and the hands on the face may either be quite still or they may mislead instead of guide. The same simile may be used appropriately concerning a hospital accounting system. If the "accounting system" watch does not disclose the correct time readily and reliably, it has no economic value.

It has been said several times by eminent medical doctors that the science of medicine is fifty years ahead of the practice of it. Is this statement really a challenge to our hospitals? The hospitals provide the doctor's workshop. If some of the known advantageous medical procedures are not practised, to what extent must the hospitals supply more aids and more efficient services to do their part towards enabling the doctors to catch up more closely with the advances of medical science?

Assistant to the Editor Chooses Home Career

It was with much regret that the Editorial Board received the resignation of Mrs. Robert Baker who for a number of years has been Assistant to the Editor. Coming to the Canadian Hospital Council as Miss Eleanor Wrenshall, a recent graduate of Trinity College, University of Toronto, she very quickly made herself invaluable in the many exacting duties associated with the preparation and publication of the Journal. A major share of the credit for the careful editing, well-balanced pages, and happy choice of type, should be given to Mrs. Baker. The best wishes of the Editorial Board and the staff go with her for the years to come.

Mrs. Baker will be succeeded by Miss Jessie Fraser who was associated with Dr. Agnew for several years in the Department of Hospital Service of the Canadian Medical Association. Miss Fraser was graduated from the University of Manitoba, later taking a Master's degree, and has had considerable editorial experience. She will be ably assisted by Mrs. Mary Cottingham as writer and editorial assistant. A recent addition to the staff is Mrs. Eileen Scott.

Negro Blue Cross Plan

Moton Memorial, a negro hospital in Tulsa, Okla., has organized the largest single community group that is enrolled in the Oklahoma Plan. Dr. William B. Perry, the hospital's administrator and director, believes that Blue Cross can largely solve the health needs of the Tulsa negroes. Eight hundred and fifty families joined the Blue Cross Plan, giving protection to 3,300 persons.

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can purchase
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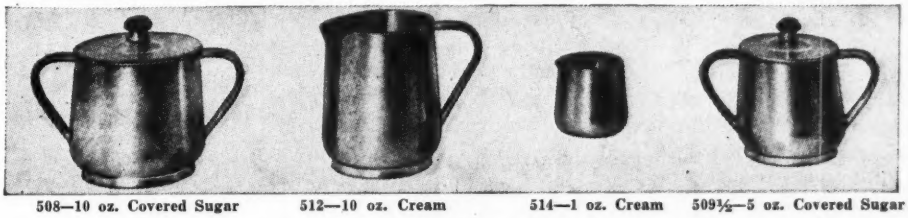

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REFERENCES ON REQUEST

Provincial Notes

(Continued from page 70)

the earliest possible date. The new building will have a 471-foot frontage and will accommodate forty beds. Already the Shrine circus committee has donated $10,000 toward the hospital fund.

Ontario

KITCHENER. The Kitchener-Waterloo Hospital Commission has made an offer of $6,000 to city council for the hospital annex, formerly the CWAC camp hospital at Knollwood Park. The offer stipulated that the amount is to be paid off in five annual instalments of $1,200 each, plus interest costs.

* * * *

HURDMAN'S BRIDGE. Rideau Veterans' Hospital, known during the war years as Rideau Military Hospital, is to revert to its original owners, the Grey Nuns. Part of the health and occupational centre at Billings Bridge is being converted to accommodate about sixty-five active treatment patients and it is expected all patients from the former military hospital will be housed there. The X-ray equipment will be transferred to the Aylmer Building in Ottawa and will be used in the Department of Veterans' Affairs out-patients' clinical department.

* * * *

LONDON. The Board of Trustees of the Victoria Hospital here have accepted both the site recommended and the architect's plans for the new 200-bed wing at the Ottaway Avenue Hospital. The new V-shaped addition will be built at the rear of the present main building and will cost around $1,386,000. The addition will also house the new cancer clinic. The proposed wing will be seven storeys high, including the basement, and will be built on the banks of the south branch of the Thames River. Two new elevators in the addition planned for early construction will cost about $50,000, while a spare boiler to provide insurance against emergency will cost around $25,000 and will provide heating for the new addition to the nurses' residence, the children's hospital 30-bed addition, the new wing and for any extra purposes.

* * * *

LONDON. Plans are under way here for a new 30-bed wing, to increase the capacity of the War Memorial Children's Hospital to 110 beds.

* * * *

CORNWALL. The Hotel Dieu Hospital here observed its golden jubilee anniversary at a three-day celebration by members of the Religious Hospitallers of St. Joseph, who operate the hospital, and the community. In 1897 the first hospital of 30 beds was opened and during the past fifty years there has been a wide expansion in services and facilities. An extensive building program is under contemplation at the present time.

* * * *

ST. MARY'S. The ratepayers have approved plans for a $125,000 debenture issue for the building of a new

(Concluded on page 82)

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FREE FROM ADULTERANTS, preservatives or fortifiers, their use eliminates wide variations in flavor and consistency experienced with average market fruit . . . as Sunfilled presents a unique blending of sweet and sour juices for uniform values. In ready-to-serve form, they closely approximate freshly squeezed juice in all nutritive and characteristic properties. Of dietary importance, the indigestible peel oil fraction has been reduced to but .001%.

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SEALSKIN LIQUID PLASTIC SKIN ADHESIVE

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USE 3 WAYS

★ SEALSKIN to adhere dressings or bandages to the skin—wound dressings — skin traction bandages, etc.

★ SEALSKIN in place of tincture of benzoin to prevent adhesive plaster skin reactions. Apply a protective coating to the skin before applying adhesive plaster. It peels off with the plaster leaving no debris.

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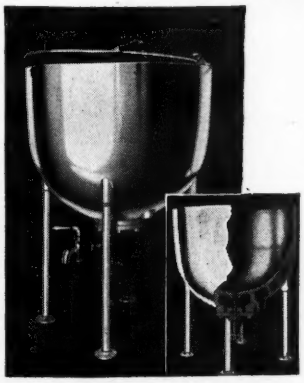

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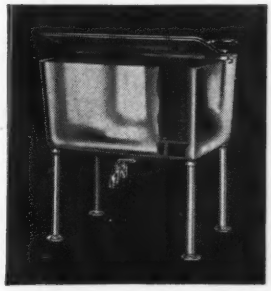
Deep Stock Pots; with or without spigot. Your choice of cast aluminum or steel spun covers.



Steam Roasters; one piece construction for quick heating, easy cleaning. Unusually small amount of shrinkage in meats.

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Provincial Notes

(Concluded from page 80)

hospital here. The debenture issue is for a 20-year term to finance the purchasing of a site and the construction of the proposed Memorial Hospital which will have not fewer than thirty beds.

* * * *

KINGSTON. Purchase of a house, which will be converted into an auxiliary nurses' home, has been approved by the board of governors of the Kingston General Hospital. The building, which will house twenty nurses, will be enlarged in the future to accommodate other members of the nursing staff. The house stands on a quarter-acre lot and was constructed in 1858 of yellow gloss bricks imported from Belgium. Purchase price of the property was said to be $35,000.

* * * *

PERTH. Recent purchases of the Great War Memorial Hospital here include a fluoroscope which now makes possible the taking of x-rays in the fracture room while fractures are being reduced.

Quebec

GRAND'MERE. A contract has been awarded and work is expected to start immediately on the construction of a $750,000 hospital at Grand-'Mère. The Quebec Government has made a grant of $200,000 and the city has contributed $100,000. The hospital is being built under the auspices of the Daughters of Jesus.

Nova Scotia

PARRSBORO. South Cumberland Hospital was recently opened at Parrsboro. The building was purchased from commissions of $5,000 earned by Parrsboro and district Victory Loan salesman, who formed the Parrsboro Charity Association for the purpose of administering the fund they had built up. Subscriptions amounting to some $7,000 were collected to take care of necessary alterations and repairs. The building was approved by the Red Cross Society Outpost Hospital Committee and has been well equipped by the Red Cross.

BOOK REVIEWS

(Concluded from page 68)

unsound mind; the loss of patients' property; births and deaths in hospital; professional confidence and cognate matters; ownership of medical records; poison; professional qualifications; the law of master and servant; statutory regulations of conditions of employment; hospital rates, taxes and duties; recovery of charges; trespass; contracts; sale of goods; insurance; the nurses contractual provision and the National Health Service Act, 1946.

While a fair proportion of the material contained in this volume relates specifically to the situation in Great Britain, there is much of the work which is directly applicable to hospitals in this country, particularly that which relates to hospital law. Law in Canada is based primarily on English law, although in the Province of Quebec there is a French as well as a British heritage. English decision and principles weigh very heavily in our courts and this practical exposition of basic principles and viewpoints should be very helpful.

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Lowering Standards

(Concluded from page 56)

result in the acute financial embarrassment that faces hospitals today. This is traceable to the fact that sufficient profit was realized from the operation of the private and semi-private wards to offset the deficit incurred in the care of indigents. In these days of mounting costs such profits have largely disappeared and private and semi-private services do well if they carry themselves. Mounting costs have also substantially increased deficits on public ward services because either there has been no corresponding increase in government subsidy or the increase has not been commensurate with rising costs.

From an examination of the foregoing facts it would appear obvious that a more realistic approach to this problem on the part of the government is imperative and long overdue. The time has arrived for the government to assume the full cost of caring for the medically indigent. If this is done I am convinced that the increasing costs of hospital services can be met without lowering present standards.

The solution of this problem, as I see it, has been stated boldly, succinctly and without elaboration. The embroidery of details has been avoided because detail is unimportant and serves only to becloud the issue. What is needed is recognition of, and agreement on, the cardinal principle. If this is achieved the details of implementation will offer no difficulty. I would suggest that discussion might most usefully hinge on the validity of the basic principle—*that the state assume full responsibility for the hospital care of those of its citizens unable to provide for such care out of their own resources.*

Dietetic Appointment

Miss Kathleen Jeffs of Montreal was elected president of the Canadian Dietetic Association at its annual meeting in June.

Coming Conventions

September 2-12—Chicago Institute for Hospital Administrators, University of Chicago.
September 8-12—A.C.S. Clinical Congress, Waldorf-Astoria Hotel, New York City.
September 21-22—A.C.H.A. meeting, St. Louis, Mo.
September 22-25—American Hospital Association, Jefferson Hotel, St. Louis, Mo.
October 14-15—Saskatchewan Hospital Association, Bessborough Hotel, Saskatoon.
October 15—Manitoba Hospital Association, Royal Alexandra Hotel, Winnipeg.
October 16-18—Canadian Hospital Council, Royal Alexandra Hotel, Winnipeg.
October 20-25—Alberta Institute on Administration, Edmonton.
October 25—Associated Hospitals of Alberta, Edmonton.
October 28-31—British Columbia Hospitals Association, Victoria.
November 3-5—Ontario Hospital Association, Royal York Hotel, Toronto.

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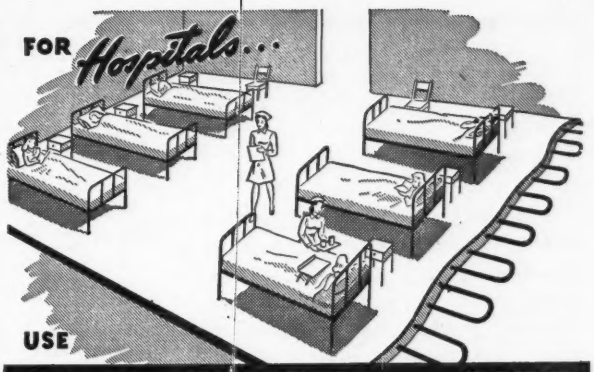

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Training of Personnel

(Concluded from page 41)

to be further supplemented by individual instruction on the job by the employees' immediate supervisor. This is most important.

Training Teachers

From the foregoing discussion it will be obvious that, even with a director of training, much of the actual teaching will devolve upon department heads and their subordinate supervisors. Consequently a course for training these leaders is a necessity and an essential part of the entire training program. First of all, these teachers must be made familiar with the content of the basic training course, the lecture course, given all non-professional employees. Without this knowledge they can not do effective follow-up when these people are on the job. Beyond that, they must know how to teach their departmental courses and how to impart instruction in job skills. In short, these supervisors must have a knowledge of the fundamentals of good teaching and effective teaching. The American Hospital Association's Bulletin on Training of Lay Personnel summarizes these fundamentals as follows:

1. Knowledge of the institution, the department, the job.
2. Understanding the individual.
   (a) The individual as a unit, including personality development, basic needs and desires.
   (b) Recognition of the individual differences.
   (c) Reasons for discontent.
3. Knowledge of how the worker learns—habit formation.
4. Arousing and maintaining the interest of the worker.
5. Knowledge of training techniques.
6. The psychology and technique of giving instruction which includes:
   (a) clarity of expression; and
   (b) manner adapted to individual and situation.
7. Building morale.

It is recommended that the administrator or the director of training conduct this course for the leaders. If possible, however, an expert should be called in to lecture on individual differences and the psychology of learning. The T.W.I. program prevalent in the United States during the war was an excellent example of such a leaders' training course.

Whatever the method used, the training of supervisors or group leaders is, as mentioned before, absolutely essential to the success of the entire training program. Furthermore, supervisors must realize clearly that it is part of their duty to do a good training job and to the extent that they fail, they are failing in the function of supervision. Convincing supervisors of this duty and giving them a start in carrying it through is part of good hospital administration.

Rickets Still Found

Not enough milk and too much candy causes 10 per cent of suburban children to suffer from rickets, Dr. E. W. McHenry, professor of nutrition at the University of Toronto, said at an Ontario conference on social welfare recently. Although doctors have known the cause of rickets for more than 20 years, the disease is still to be found throughout this country.

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CWA Bulletin

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Watch For Further Announcements.

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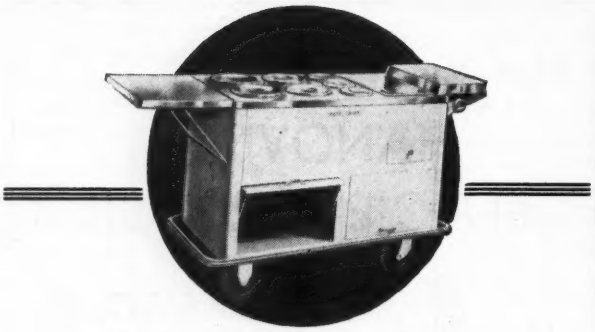

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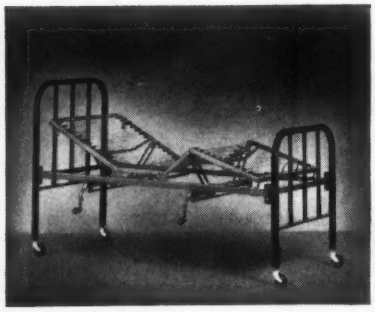

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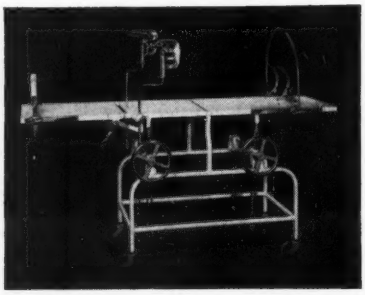

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